mental health digest

National Clearinghouse for Mental Health Information, Vol. 2, No. 1, January 1970
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cover story

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The picture symbolizes the growing use of computers as aids to sensitive and creative scientists and practitioners in their quest for a better understanding of the complexities of human behavior.

mental health digest

The *Mental Health Digest* is a monthly publication designed to reflect the whole spectrum of mental health and to present a broad sampling of scientific subject matter and professional points of view. It contains condensations of material selected from the current mental health literature.

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Survey of State-Level Programs in Mental Health Statistics

KURT GORWITZ

The first U. S. facility for the mentally ill was the Pennsylvania Hospital in Philadelphia, which opened in 1752 as a general service and established a program "for the reception and care of lunaticks." One of the first two patients was mentally ill. The first hospital specifically for the mentally ill was the Eastern Lunatick Asylum at Williamsburg, Va., which accepted its first patient in 1773. The first privately operated mental hospital, the Friend's Asylum, opened at Frankford, Pa., in 1817.

In the early period of asylum care, little thought was given to the need for statistical records or reports. Names of patients were recorded in a book in chronological order. Sometimes this information was supplemented by age, nativity, and place of residence. When patients died or were discharged, appropriate notations were made. Some larger facilities used a census book which showed the daily number of patients in residence and of admissions, discharges, and deaths.

The Association of Medical Superintendents of American Institutions for the Insane, predecessor of the American Psychiatric Association, was established in 1844. At its founding a committee on statistics was established. In the same year, the *American Journal of Insanity* was founded. One article in the first issue was "Number of the Insane and Idiotic, With Brief Notices of the Lunatic Asylums in the United States."

Despite a few early reports, routine statistical programs were not established until care of the mentally ill was legally recognized as a State responsibility. Probably the first program was in Massachusetts, where the State Board of Health, Lunacy and Charity began to publish statistical data in 1879. New York established the first statistical bureau in 1911. Illinois, Iowa, and Ohio have had a fairly extended history in this field. A few individual facilities, such as the Worcester (Mass.) State Hospital and the Warren (Pa.) State Hospital have for some time had comprehensive statistical information. In 1949, when the National Institute of Mental Health made a study of statistical programs, it found only 11 States with an organized and functional statistical service.

In 1951, the National Institute of Mental Health invited mental hospital administrators and statisticians from these 11 States to a conference which led to the establishment of the Model Reporting Area for Mental Hospital Statistics. It adopted the following statement of purpose:

> The need for uniform, comparable, and meaningful statistics on the mentally ill of the Nation is recognized by all who are concerned with this problem. In order to embark on the immense task of solving, in a constructive and cooperative manner, the complex problems involved in gathering such statistics, a group of State mental hospital authorities, with the aid and counsel of the National Institute of Mental Health, have joined together in the Model Reporting Area for Mental Hospital Statistics. The objectives set forth by this group are:
>
> 1. Development of a strong central statistical bureau in each State mental hospital system.
> 2. Development and use of standardized definitions of the various categories of mental hospital patients.
> 3. Production of a standard set of basic

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tabulations which every State hospital system should have.

4. Use of statistical methods appropriate to the analysis of data on patients followed for long periods of time.

It is the further purpose of this group to aid and encourage other States throughout the country to meet the standards of the Model Reporting Area so that all may contribute to the understanding and elimination of mental disorder as a major national health problem.

Annual meetings were held until 1965, when it was dissolved in order to develop a broader program involving both inpatient and outpatient services in all 50 states. By this time, the States able to produce the annual patient movement tabulations required for membership had increased to 36.

But figures on past and present State mental hospital statistics programs, such as staff size, cost of operations, and data output, were not available. To bridge this gap, I asked directors of these programs to complete a questionnaire during the 1965 Model Reporting Area conference. Data summarized here are from this survey, together with other statistics from a second, more comprehensive survey conducted in 1968 in a similar manner among the same group of people. Questionnaires were completed by statisticians from 46 States plus the District of Columbia (all except Alaska, Texas, Vermont, and Wyoming) for the 1965 survey and by statisticians from 47 States plus the District of Columbia (all except Minnesota, Mississippi, and Washington) for the 1968 survey. In addition, unpublished data on State salaries were provided by the Biometry Branch, NIMH, from an informal survey conducted in 1963.

In 1968, 45 of the 48 State directors of mental hospital statistics had graduated from college and three had attended but not completed college; 23 had a bachelor's degree, 17 a master's, and five a doctorate. The specialty most frequently listed for the highest degree earned was psychology, followed by sociology and mathematics. Two directors reported degrees in biostatistics and four had degrees in unspecified areas of statistics. The other 14 cited degrees in eight different specialties.

In 1968 a majority of respondents had been employed as mental health statisticians for five years or more. The median length of continuous employment declined from 6.3 years in 1965 to 5.5 years in 1968, so that in 1968 one of four had been in this field less than two years as compared with one of six in 1965.

In 1963, the median annual salary of State mental health statistics directors was $7,850. In 1968, it was $11,333. In 1968, three directors had annual salaries of $20,000 or more; none was in this category in 1963. In 1968, nine had salaries exceeding $15,000 in contrast to one in 1963. The number earning less than $10,000 decreased from 38 in 1963 to 16 in 1968.

In addition to a director, the programs had a median of 4.4 clerical and 1.4 professional employees. Both figures are slightly higher than in 1965. However, the figures are inflated since several States indicated that their count included employees not directly working in statistics or primarily involved in some other phase of health statistics.

In 1968 the directors were asked whether during the preceding three years they or their staffs had presented papers at meetings or had papers published; 33 reported no papers presented and 32 reported no publications. Twenty-eight had neither presented nor published. Fifteen reported

a total of 64 papers presented, and sixteen a total of 45 papers published. Only one State's staff (Maryland) had presented and published five or more papers. Similar responses had been obtained in the 1965 survey.

The directors were asked whether they routinely collected patient movement data from facilities for the mentally retarded, private psychiatric hospitals, and outpatient psychiatric centers. The number stating that they did was 34, 18, and 37, respectively. While 13 States reported that they received data from all three types of facilities, five stated that their program was limited to State mental hospital statistics. The remaining 30 had a variety of combinations.

The 43 States that supplied financial data had a median annual operating budget of $38,888 for statistical services. My estimate is that the 50 States plus the District of Columbia annually spent between $4 million and $4½ million for mental health statistics programs, or approximately .25–.30 percent of their total budgets. Nearly half this amount was accounted for by the six States with the largest expenditures.

In fiscal 1968, there were 2.6 statistical employees per 1,000 total employees in mental hospital programs. While this ratio was highest in States with a staff of less than 1,500, a number of the States have only one hospital and combine statistics and medical records programs. Most other States, including the six with a statistical staff of 20 or more, had a ratio slightly lower than the national average.

Only five States reported that they have research grants related to mental health statistics. While these grants amounted to approximately $1,750,000 per year, more than three-fourths of this amount was accounted for by a single grant to New York. The Biometry Branch, NIMH, has expended some of its operating funds since 1961 for the joint administration with the Maryland Department of Mental Hygiene of a Statewide psychiatric case register. It is evident that most mental health statistics offices are supported from State operating funds and do not receive supplementary financial support from other sources. The impact of Federal funds, with few exceptions, has been minimal.

The directors stated that their programs would require an additional 174 professional and 164 clerical employees in the next five years. This requirement would double current professional staff and increase the clerical force by 50 percent. The six most populous States accounted for 33 percent of the indicated expansion in professional staff and for 40 percent of all additional professionals and 31 percent of all additional clerks. Should these changes occur, 50 percent of the professionals and 44 percent of the clerks would be working in the six largest States.

The statistical staff in the six largest States had a high ratio of professionals to clerks (roughly three to four). In the 14 States with less than one million inhabitants this ratio was less than one to four. While this disparity would be somewhat reduced by 1973, if anticipated plans materialize, it would still remain quite substantial.

These data point to wide variations in the levels of State mental hospitals statistics programs. Although statistical services appear to have progressed since 1951, the following 1968 data suggest that most programs need improvement: in about half of the States surveyed, directors do not have a graduate degree and earn less than

$12,000 per year; the total size of the statistical staff is less than seven and primarily clerical; the annual operating budget is less than $50,000, or about 0.25 percent of the total cost of operations; and special papers have not been presented or published in the past three years.

It seems that the goals of the Model Reporting Area for Mental Hospital Statistics have not yet been realized in most States. While the organization did not describe the characteristics of a strong bureau, a director with graduate education in biostatistics or other appropriate fields, sufficient clerical and professional personnel, and an adequate budget would surely be required. Based on data related to these criteria, programs in approximately 10 States can be rated as strong, about 20 as weak, and the remaining 20 between these extremes.

Further improvement is necessary and needs to be concentrated in three areas: improved education and training of biostatisticians, more effective use of available data, and expanded and better relationships between biostatisticians, administrators, and other professional mental health workers.

The research potential of mental health data has not been adequately recognized in the majority of States. We can only speculate as to the reasons for this failure. The fact that many directors are overwhelmed with routine work is an important reason. Another might be the limited knowledge that some directors have of research and of research needs and techniques.

State directors of mental health statistics attend annual national meetings sponsored by the National Institute of Mental Health. It would be valuable if these meetings, as well as regional meetings, provided a setting for reviewing research, discussing techniques, and fostering the development of cooperative interstate projects. In many States, statisticians need to develop channels of communication with psychiatrists, psychologists, and sociologists.

The Federal Government must play a key role if these objectives are to be attained. Encouraging development of basic data banks, providing outlines for minimum annual tabulations, suggesting qualifications and salary levels for staff, developing training courses, fostering communication and cooperation with biostatistics and mental health departments in schools of public health, and assisting in the growth of interstate projects are examples of areas where efforts need to be intensified.

Human Brain Protein, Drugs and Dreams

IAN OSWALD

I intend to draw together several long-term processes affecting brain cells. These "slow neurophysiological swings" interest the psychiatrist, for he sees, reflected in his patients' behavior, evidence of slow brain changes over weeks, months, and years. A common illness is endogenous or autonomous depression—autonomous because it is self-perpetuating. It can be treated with a drug such as imipramine; although this reaches the brain within hours, the mood does not begin to lift for 10 days or more, and many more weeks or months of treatment are needed. There can thus be responses delayed and gradual on a slow time scale. British neurophysiology, oriented more to milliseconds than weeks, has offered little to the psychiatrist. Recently, things have begun to change, chiefly through work of neuropharmacologists, and it is the action of drugs on the brain that has been my starting point.

Addiction to a drug both develops and decays on a time scale of weeks. My first encounter with a slow human brain change came while studying sleep of amphetamine addicts. The measurements were of REM sleep, the phase of sleep especially associated with dreaming. Amphetamine suppresses this kind of sleep, but repeated consumption leads to tolerance, including a return of REM sleep to the normal 20–25 per cent of the night. Withdrawal of the drug then causes a "rebound" increase to more than normal REM sleep and makes REM sleep start early during the night. Data from six addicts suggested a return to normal in about three weeks, but a careful look suggested that recovery was actually taking a couple of months.

Barbiturates also suppressed REM sleep duration and reduced the profusion of actual eye movements. If the drugs were administered for one to three weeks the effects lessened; after they were stopped a rebound increase of REM sleep above normal occurred which lasted more than a month. The rebound was coupled with complaints of vivid and unpleasant dreams and with more than the normal amount of eye movement during REM sleep. These observations indicate that REM sleep rebound has both duration and intensity factors.

Effects of Anti-depressants

We looked at REM sleep in patients who had taken overdoses of tricyclic antidepressant drugs. These drugs powerfully suppress REM sleep and, after overdose, a rebound, with intense dreams, appears and recovery to normal takes a month.

Suppression of REM sleep is not a property of all drugs that act on the central nervous system. Some, like fenfluramine and iprindole, have no immediate effect, while others, like L-tryptophan or reserpine, increase REM sleep. We have conducted experiments with heroin on ourselves; the REM sleep rebound persisted for more than two months. There is a similar time course of recovery after an overdose of a second type of antidepressant treatment—electroconvulsive therapy. ECT induces abnormal slow waves in the waking electroencephalogram. After a conventional course of twelve

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ECTs, sophisticated techniques show a five-to-seven week EEG recovery.

There are similar recovery curves in animal brains. The nerve gas, "Sarin," rapidly renders inactive, or destroys cholinesterase and with it, in all probability, the machinery for producing brain cholinesterase. Recovery is believed to be dependent on synthesis within the brain cells of new machinery for the production of the enzyme. This process begins promptly but requires many weeks.

Importance of Synthesis

Reserpine depletes the brain of monoamines, including the catecholamines, which are present in certain neurones within special storage particles. Administration of 5 mg/kg of reserpine to rabbits makes brain catecholamines abruptly disappear. The reserpine itself disappears from the brain in a few hours. The recovery curve is on a time scale of weeks. The catecholamine stores in the neurones can be stained and photographed, and the slowness of recovery led to the proposal that it was dependent on the formation of new storage particles in the cell bodies—not a restocking of old cupboards, as it were, but a stocking up in new cupboards which have to be synthesized afresh during the repair process.

The peak of REM sleep rebound after the tricyclic drugs and heroin is delayed for about 10 days. Drug-accentuated EEG sleep spindles after treatment with the tricyclic drugs disappear, and so do urinary products of heroin just before the night of peak REM sleep. It takes about a day for amphetamine and sodium amylobarbitone to be eliminated from the body, and peak REM sleep rebound then seems to occur following the first day of abstinence. Nitrazepam, an effective hypnotic, causes drug-induced fast activity in the drowsy EEG which persists for 48 hours. Peak REM sleep rebound after treatment with nitrazepam is delayed to the third night.

The rate of increase of REM sleep seems to relate to the rate of disappearance of the drug from the brain; the peak of rebound seems to follow closely on the disappearance of the drug, and the increase in REM sleep after reserpine may be an immediate "rebound" consequent on the rapidity with which reserpine disappears from the brain. Thus the term "rebound" may not always be apposite, and increased REM sleep may rather be a sign of certain types of neuronal repair.

I propose that the REM sleep rebound after drug withdrawal indicates a reshaping of neuronal machinery through protein synthesis, a process of repair within brain cells. I am not proposing that all kinds of active repair are accompanied by an increase in REM sleep, though I would suspect it whenever 5-hydroxytryptamine or noradrenaline played a major part in the machinery being repaired.

Dream Compensation

There is a technique for selective deprivation of REM sleep by behavioral means. On undisturbed nights REM sleep is increased. The original explanation was in terms of "compensation" for lost dreams, for which, it was supposed, there was a compelling "need." This explanation has fallen out of favor, but "compensation" could be advanced as the basis of post-drug REM sleep rebound. The degree of "compensation" seems to have been small in most experiments involving selective

deprivation, and completed within a week.

The largest compensation seems to have been about 60 percent. In terms of hours of REM sleep, the rebound after barbiturates, tricyclic drugs, or heroin is about 150 percent. I have mentioned the intensity increase after drugs. It is present, too, after behavioral deprivation, but there is nothing to suggest that it is greater after the latter. The build-up of an "autotoxin" which could be removed by REM sleep alone has been proposed. As the proposal was formulated it is hard to see the autotoxin causing a 150 percent compensation in duration alone. The immediate increase of REM sleep caused by some drugs certainly cannot be regarded as "compensation."

Slow brain change is seen not only in recovery after drugs. When drugs such as morphine or barbiturates are administered repeatedly, tolerance appears in days and increases to near completeness in weeks and months. The effects on REM sleep lessen, but the adjustment process may be complicated by short-term mechanisms, and by induced adjustments of liver function which tend to inactivate the drugs before they reach the brain. The period of drug exposure would be regarded as one in which not only the liver but also the brain was adjusting to the presence of the drug, paralleling the development of tolerance. During the rebound period there would be simply a slow brain change uncomplicated by the liver.

There are grounds for believing that the rate of intraneuronal synthesis which accompanies the development of tolerance to morphine is increased above normal and the same might be suspected for the reverse process of active recovery. I have referred to increased intensity of REM sleep during recovery rebound. During the development of morphine tolerance an increased rate of synthesis of 5-hydroxytryptamine (5–HT) has been demonstrated.

It can now be noted that (1) withdrawal of the morphine-type drug, heroin, would presumably leave a persisting mechanism for increased synthesis of 5–HT, which, soon unrestrained by the continuing presence of the drug, would accompany and increase of REM sleep above normal, (2) reserpine depletes stores of 5–HT but causes increased synthesis of 5–HT and increased REM sleep, an (3) L-tryptophan and 5–HTP can enhance REM sleep, presumably by temporarily increasing 5–HT synthesis.

Amines and Sleep

I said at the beginning that clinical response to imipramine was delayed for 10 days or more. The same is true of the other group of antidepressant drugs, the monoamine oxidase inhibitors (MAOIs). Just as I believe we must devote more thought to slow and gradual brain processes, so we shall have more often to consider delayed processes. Again sleep research offers a tool. The administration of phenelzine can sometimes seem at first to promote REM sleep at the beginning of the night, but, when used in clinical doses, it causes a moderate overall reduction in REM sleep. We have, however, found that phenelzine, after a delay of up to 21 days of regular administration, will cause a further abrupt response, total REM sleep abolition. Far from such "loss of dreams" causing psychological impairment, the total abolition of REM sleep, which can last many

weeks, is accompanied by improvement of mood.

I can now return to the subject of slow recovery of emotional balance. I must first add that healing of injured body tissues includes removal of clots through fibrinolysis. This process is brought about by plasmin, derived from plasminogen in the presence of plasminogen activator. The amount of this activator in blood is normally controlled by the brain. Whether this implies direct release from, say, the hypothalamus, or hypothalamic control through a target organ, is not known.

I have mentioned experiments with heroin. As others had observed, we found that in the healthy person heroin not merely failed to cause euphoria but was frankly unpleasant. Why? If neurones undergo active modification owing to involvement in the impact of emotional distress, whether of physical or social origin, it would not be surprising if the response to heroin of the neurones of the distressed person were different from that in the normal person.

Synthesis Within Neurones

I suggest that REM sleep rebound betrays increased protein synthesis in the brain. I would go further and propose that REM sleep is a nonspecific indication of many forms of synthesis within cerebral neurones, which would explain the "strange" finding that streptomycin (an inhibitor of protein synthesis capable of damaging human neurones) reduces REM sleep. The proposal is consistent with the uniquely high proportion of REM sleep in the two months both before and after birth in animals, such as the human, in which the central nervous system is not mature at birth. During these months the finer differentiation of the brain occurs. It is also consistent with the increased brain blood flow and temperature during REM sleep. NREM sleep is especially enhanced after strenuous physical exercise and is accompanied by a high concentration of growth hormone in the blood, suggesting that its chief function is for bodily restitution, while REM sleep may be chiefly for brain repair. I could also predict that conditions associated with massive learning would cause high percentages of REM sleep, e.g., when an "enriched" environment for growing rats leads to a heavier brain cortex and greater development of glial cells. Human mental retardates have REM sleep reduced both in amount and intensity.

Finally, it seems to me that, in the study of brain and behavior, we shall be compelled to think in terms of slow shifts of function mediated by protein synthesis. So far the latter has scarcely entered the psychiatrist's conceptual framework, but it seems as probable that it underlies personality modification through psychotherapy as that it underlies drug tolerance or REM sleep rebound. The healing of hurt minds proceeds by processes as slow as the healing of hurt brain cells.

Sex Differences in Children's Modes of Aggressive Responses Toward Outsiders

Norma D. Feshbach

Research on sex differences in aggression indicates that during preschool and early childhood years boys manifest more aggressive behavior than girls. Several studies have reported greater verbal aggression in girls. Anti-social aggressive responses and socially approved forms of aggression—pro-social aggression—have been distinguished. Boys manifest more anti-social aggression, girls more pro-social aggression.

The wide range of possible aggressive behaviors permits other distinctions to be made. Physical attack, verbal assault, and fantasies of violence are clear instances of aggression. However, if aggression is conceived of as a motivated sequence of behavior, the goal of which is to inflict pain, then there are many less obvious indirect methods.

Since studies of aggression in children have encompassed a limited range of aggressive responses, there are few data regarding sex differences in the use of these indirect social means of inflicting pain.

The purpose of this investigation was to provide a situation in which the incidence of this behavior as well as the frequency of direct aggressive responses could be observed. The procedure entailed organizing children into two-person groups and observing their responses to a newcomer. Eighty-four children were randomly assigned to the two-person groups and 42 children were randomly assigned to the newcomer or "outsider" role. The 65 boys and 61 girls were in the first grade and came from middle-class backgrounds.

Two children of the same sex were selected from the same classroom. Efforts were made to develop group cohesiveness by telling them that they were a special club. The children were provided with a club name and badges, and told that they would have a second club meeting the following week. Then the children played for 14 minutes.

One week later, the same pair returned to the experimental room. Group feeling was re-evoked by reminding the children of the previous meeting. The group members were then informed that another child was joining the group. The newcomer was from a classroom other than that of the original pair. To half of the original pairs, a same sex member was added. This procedure resulted in the following experimental groups: 11 all-boy groups (BBB); 10 all-girl groups (GGG); 11 two boy, one-girl groups (BBG); and 10 two-girl, one-boy groups (GGB).

Toys of high interest for this age and which lent themselves to individual and group activities were attractively arranged in a 16 x 10 foot room. The toys included a set of battery-operated telephones, two wooden puzzles, three table games, six small musical instruments, a set of dishes, small wooden trucks, and a cash register. A Bobo Doll present during the first session was omitted from the second session since pre-testing had shown that boys and girls differed in their use of this toy.

In a corner was an observation

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screen which provided a booth for a concealed observer who was not informed of the experimental hypotheses and was present during both play sessions.

The observer rated the children's interactions on direct aggression, indirect aggression, and approach. Included under direct aggression and separately scored were physical aggression, verbal aggression, and expressive aggression (sneering, threatening gestures). Indirect aggression included ignoring, avoiding, refusals, and excluding. Approach included friendliness (praising, hugging, smiling), compliance, cooperativeness, and dominance (of a nonaggressive type).

During the first session sex differences were small. However, the scores do not reflect the aggression toward the Bobo Doll, which the boys pummeled and kicked far more often than did the girls.

In the second session, there were no significant differences in the frequency of direct aggressive responses between the sexes.

Analysis of the indirect aggression scores showed that the initial response of girls to a new member was more likely to be exclusion and rejection. But the unfriendly response of girls was an initial reaction which dissipated with time.

None of the comparisons between boys and girls in the frequency with which they approached the new child was statistically significant.

Dominance, which was scored when a child gave an order to another child, is a form of power assertion. As such it may be viewed as direct aggression although dominant responses do not conform to the criterion of infliction of injury. Dominant responses occurred infrequently. While the boys tended to make fewer dominant responses toward a girl than a boy newcomer, there were no significant sex differences.

The newcomer made fewer responses than the other children made to him or to each other. There was evidence of differential responsiveness by the newcomer to the different sex groupings. The boy newcomers displayed more direct and indirect aggression than the girls.

The results raise some interesting questions concerning the pattern of sex differences in aggressive behaviors. Though boys were more abusive to the doll, there was no sex difference in direct aggression and the girls were initially more unkind to a peer with whom they were unfamiliar. The patterns of aggression were undoubtedly influenced by the situation. Very little physical aggression was exhibited. The situation did facilitate evocation of subtle, indirect aggressive reactions to the newcomer.

Perhaps the most significant implication of this study is the need for exploring and assessing the many routes which can be taken to express hostile, aggressive tendencies. Research has been primarily concerned with aggressive content. Aggression, however, also implies injurious consequences and attention needs to be given to the diverse ways in which such consequences can be achieved.

Drugs and Aggression

HENRY BRILL

Much is known about the effect of some drugs in precipitating aggression, and about the influence of others in suppressing it. I should like to call attention to a blind spot in psychopharmacology and its research: the way in which all work seems to ignore the possibility that drugs may control pathological aggression.

Much violent crime is the expression of pathologic aggression. "Crime in the streets" is only partly to be understood in terms of logical criminal motives; much more is an expression of poorly understood anger and hostility which seems to serve no understandable purpose other than to express pathologic emotions. This is even more true of other crime, much of which finds expression in the home and is directed against family, friends, and neighbors.

Why has so little attention been paid to pathologies of the emotion of anger and its expression in violence compared to what has been done with anxiety and depression? We cannot maintain that anxiety or depression has a greater impact on our society.

Is it true that crime has no biologic aspects of significance but is sociologic in nature and to be seen only as a response to environmental stress? One searches in vain for mention of the fact that pathologic rage should be considered a target for biologic investigation and psychopharmacologic intervention. Experience in forensic psychiatry shows that a large number of perpetrators of violent crimes cannot account for their behavior except as an overflow of anger which, in retrospect, they consider to be pathologic and responsive to some inner factor for which they cannot account. Environmental factors play a significant role in aggravating tension and precipitating action, yet the response is far in excess of normal. Often the behavior appears to be endogenous and the factors of stress must be derived by psychodynamic procedure. Here we include the sexual aggressions, senseless violence that complicates minor crime, and sadistic acts against individuals.

It is a curious fact that the psychopharmacology of alcohol and drugs of abuse are credited with contributing much to such violence, but this does not seem to lead to an exploration of the idea that behavior precipitated by one type of pharmacologic agent may be controlled by another of opposite action. This is especially curious because pharmacology has innumerable examples of pairs of substances which have opposite actions. This is a general principle which extends not only to glands of internal secretion and muscular action but reaches into the sphere of so-called psychic functions. Reactions at the psychic or behavior level are not as clear-cut or as regular as they are in tissue preparations, but they do not seem to be different in principle.

Alcohol is recognized as a disinhibiting, aggression-provoking substance that plays a role in some 60 per cent of homicides either in the killer or the victim, an indication that when people drink together the stage may be set for murder. The barbiturates are less well known in this connection than is alcohol, but "on the street" pentobarbital is considered even more likely to precipitate sudden violent behavior. These conclusions

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have been extended in the public mind to all the addictive drugs, including heroin, morphine, and other opiates, whereas these last are examples of drugs that have an anti-aggressive action.

The contrasting effects of alcohol and opiates may be seen clinically in cases who alternate in dependence between alcohol and opiates. This shift is accompanied by a corresponding alternation between overt and dangerous aggression under the influence of alcohol and deep apathy with peaceful withdrawal while under the opiate. Other drugs seem to have a pacifying effect and produce anergia and loss of initiative. This occurs with the hallucinogens as a chronic effect after repeated use. In spite of statements to the contrary, heavy use of cannabis is described as having a similar effect. These drugs lower the drive to action, whether constructive or not. Paradoxical results occasionally occur when an acute paranoid episode may be precipitated. Cannabis has a direct short-term sedative effect which is probably different from the long-term tension reduction of the hallucinogens. The major stimulants are credited with a direct and acute effect on aggressive behavior, and abusers of these drugs have been implicated in more than their share of aggressive crime.

In mental hospitals we noted a decrease of aggressive tension as the first effect of psychotropic drugs. This occurred before there was change in delusions, hallucinations, or other psychotic content, and it produced a change in ward operations which revolutionized State-hospital practice. The relief of psychotic aggressive tension was specific and not a result of overall drug torpor. After a brief period of somnolence, the patients became alert, active, and capable of benefiting by therapeutic programs. Furthermore, they experienced diminution of tension as a relief from an oppressive symptom.

Psychiatrists were encouraged to extend the use of tranquilizing drugs to correctional settings and to young delinquent cases who were difficult because of hostile attitudes and behavior, but results were mediocre and it became apparent that their response to tranquilizing drugs was different from that of patients with major psychoses. Our experience was typical. We administered major tranquilizers to a group of this type and some did get some relief, but these were atpyical and were considered to have a subclinical schizophrenic disorder. The rest experienced the tranquilizing effect as an oppressive and painful deprivation of initiative and aggressive capacity. It seemed to leave them defenseless and painfully anergic. We also administered amphetamine and this produced a more favorable effect. The doses were small, and the response appeared to be the same as that seen in hyperactive children; but we were unable to continue, being unable to distinguish between a euphoric effect which might lead to dependence and a true relaxation of tension. This experience leaves open the question whether the dependence-producing effect might not be separable from the tension-relaxing one.

One may well ask why so little effort has been expended in seeking for aggression-controlling drugs which would protect the individual against a piling up of internal hostile tension or terminate it before it finds expression in violence. Such persons often have a period of time during which

aggressive tension builds up and there is good reason to think that many of them would come for treatment if it were available. At least such drugs would help the physician dealing with the aggression-ridden patient who suffers from conduct disorder without psychosis. Why then has there been so little activity and attention to the question?

We cannot explain this lag on the basis that psychiatrists have had no contact with problems of aggression. They have been called upon for more than 150 years to aid in the explanation of behavior that even to the layman seems to fall well outside the boundaries of the logical and rational. Most of the effort has been limited to establishing boundaries between cases which can be called responsible and those which cannot. The implication is that the first group should undergo punishment and only the other requires treatment, yet modern correction does not recognize punishment as its goal, and the accepted theory calls for treatment of all cases. Thus the legal question would seem to deal only with the setting in which the treatment is to be administered. The literature of criminology, however, distinguishes between the normal offender, who is a favorable case for rehabilitation, and the non-normal, who makes up a large proportion of the recidivists and who is not a favorable case.

The psychiatrist has had good reason to avoid becoming involved with such cases. He lacks an effective method of dealing with them although some psychotherapeutic techniques have been developed. Equally significant is the fact that the public confuses crime with psychosis and comes to the conclusion that since aggressive crime is often the expression of a certain kind of psychic disorder, all criminals are psychotic, and reversing the syllogism, may feel that all mentally sick persons are criminals and dangerous. Much effort has been spent in showing this not to be true and it may be that we are reluctant to become involved where the chances of misunderstanding are great and the outcome of treatment limited.

There can be no doubt that the mechanism for studying aggressive crime has been colored by the fact that the biological sciences, including psychopharmacology, have remained largely at a distance from the population of offenders. The separation between the biological sciences and criminology seems to persist in the sense that the biologic approach is limited to studies in a few primarily psychiatric facilities, while the bulk of the work in criminology seems to be left to faculties of sociology, law, and criminology.

It is my contention that this separation between criminology and biological psychiatry is a serious barrier to development in both fields and that psychopharmacology has a large potential as a field of research for methods of control of pathologic aggression.

Neural Factors Related to Habitual Aggression

Denis Williams

In the papers written about abnormalities in the electroencephalogram in those with disturbed behavior, there are many which relate to convicted criminals. No one would expect such biologically basic phenomena as those seen in the EEG to relate closely with purposeful human behavior, but it has been found that there were many abnormal EEGs in convicted criminals who through their personality defects make up a part of the failures in society, than in otherwise normal criminals who had the same spectrum of activity in their EEGs as the population at large. This might be anticipated, for no one would expect the EEG to relate to the choice of occupation nor to its value to the community.

The causal factors can be divided into those inherent in the individual and those experienced in his life; these have many names, but endogenous and exogenous will serve. The determination of each is multifactorial.

The EEG is often abnormal in aggressive psychopaths or aggressive delinquents. Although the antisocial behavior of this group is easily recognized because it is homogeneous, the members of it differ in many ways. In some the aggression is associated with mental retardation, in others with epilepsy, in another group with disorder of affect, and in another with distortion of social attitude to others. There are environmental determinants, in parental deprivation, for instance, or in other forms of emotional underprivilege.

Condensed with permission from *Brain*, 92 (Part III):503–520, 1969.

Over 1,250 prisoners who were awaiting trial for, or had been found to be guilty of, a crime involving bodily violence have been referred to me during the past 20 years for EEG examination and report. In over half the crime had been one of major violence, (murder, attempted murder, inflicting grievous bodily harm, rape or attempted rape) and in the others the crime included bodily violence (robbery with violence). In many, a history of habitual aggressive behavior had been obtained by the prison psychiatrist. They were almost all men and nearly all young adults.

A random sample of 333 forms the basis of this inquiry. The number of this sample with a history of habitual physical aggression or explosive rages was 206. The number known to be guilty of, or awaiting trial for, major crimes of violence was 152.

The subjects did not constitute a cross section of the population under penal care in Britain—indeed this survey was undertaken because the case selection made such a large number of abnormal and of otherwise normal perpetrators of aggressive crimes available for study.

Analysis showed that those who have committed a crime of bodily violence without a background of habitual aggressiveness are older, nearly three-quarters have committed a crime of major violence, mostly murder or attempted murder; over two-thirds of them had committed only this solitary major offense—in half against their wives or the woman with whom they lived, or their children. By contrast nearly all the habitual aggressives had been "in trouble" before.

About two-thirds of the habitual aggressives have abnormal EEGs, compared with only a quarter of the others. The relative distribution of the abnormality in the hemisphere is the same in the two groups—temporal, anterior temporal frontal, frontotemporal, and posterior temporal in that order. The distribution of abnormality according to the wave frequencies is the same in the two groups. In both, "theta" activity, which is associated with abnormality of the temporal lobe (as seen in patients with temporal epilepsy) is found in four-fifths of those with abnormal EEGs. The disturbance was considered to be epileptic in nature twice as often without a history of habitual aggression, and was thought to be constitutional in nature in four-fifths of the habitually aggressives, compared with a third of the others.

To see if the differences between the two groups are due to accidental factors or are "inherent" in the subject, those with disabilities suggesting structural brain damage were excluded, that is those who were backward, had epilepsy, or who had had at least one head injury with amnesia of hours or more. Then the otherwise normal habitual aggressives were compared with normal subjects who were known to have committed a solitary act of major bodily violence—in the main murder or its attempt, bodily harm, and in a few, rape. There were 68 of this group in the sample compared with 130 otherwise normal aggressives.

The otherwise normal perpetrator of a solitary major crime of violence has the same chance of having an abnormal EEG as has the population at large, while the chance of abnormality occurring in the EEG of habitual aggressives who have not had a major head injury, nor have epilepsy or mental retardation, remains over 50 percent. It is reasonable to conclude that in these the abnormality in the EEG is related to the disturbed behavior, and that it is not the direct result of unrelated structural brain disease.

The most evident result is the difference between the groups of healthy habitual aggressives and healthy men who have committed a solitary major act of aggression. A broad distinction between the two groups is that in the first the persistent aggressive response to life situations is due to the kind of person, and in the second, to the kind of life situation. This view is supported by the fact that in half the instances of murder as a solitary crime, the victim was the wife or consort. The histories of many of these men showed how potent was the environmental stress which provoked the act. Another simple distinction is that in the first group the aggression is usually unexplained, in the second usually explicable.

A second interesting result is that the abnormalities in the EEGs in the habitual aggressives were overwhelming more often in the anterior, effector part of the brain and that the part most often involved was the anterior temporal and lateral frontal areas. Third, in two-thirds of all the cases the abnormality was bilateral in these areas of the hemispheres.

Lastly, in about 80 percent of all aggressives, habitual and others, with associated neurological handicaps and without, the EEG abnormality was in the theta (4 to 7-a-second) range. This rhythmic activity has been found in other disorders to arise most often from the temporal cortex, and to re-

late most closely to lesions of the deep temporal structures within the lobe itself, the diencephalon and the mesencephalon. Its occurrence is often unexplained (as is the case with aggressives or aggressive psychopaths—a term avoided in this paper because of its ambiguity). But it occurs when tumors involve the substance of the temporal lobes, especially its deeper parts, including their medial structures and the diencephalon. These rhythms are seen to occur as a consequence of internal hydrocephalus, and of midline tumors which involve diencephalic and medial temporal structures bilaterally. Rhythms of 4 to 7-a-second, as well as slow rhythms of 1 to 3-a-second, too, are seen in well-organized forms, often bilateral and often phasic, where the mesencephalon is disordered by infections, injury, or tumors.

Bilateral patterns of activity of this kind lead the electroencephalographer to suspect dysfunction of structures near the midline in the upper brain stem, from the level of the thalamus to the lower midbrain. When there are no corroborative physical signs of structural damage, but when the correlate is a behavioral disturbance, the EEG changes tend to be linked with that correlate, notably as "epileptic disturbances" or "disturbances of psychopathic nature." There is indirect evidence that in these disorders they arise in consequence of "limbic," diencephalic, and mesencephalic dysfunction.

There has been so much attention paid to the cortical origins of EEG rhythms that recent advances in the knowledge of the modification of cortical rhythms by the activity of deep structures in the diencephalon and mesencephalon are underestimated, and in practice ignored. It is the presence of these so-called theta rhythms which offers promise to psychiatrists who use the electroencephalogram in their researches.

There is strong presumptive evidence that in the otherwise healthy subjects the disturbed behavior and abnormal EEGs were not primarily the result of neocortical changes, but of dysfunction of structures in the upper brain stem. The projection of the brain-stem reticular formation, through the non-specific internuclear thalamic reticular system to the neocortex has its greatest intensity in the temporal lobe, through the limbic structures. They are the areas from which abnormality is recorded in 88 percent of those habitual aggressives who have abnormality in the EEG. Furthermore, the type of abnormality found in many of these subjects has the characteristics to be expected when the brain stem activating structures are disturbed. The postulation is, therefore, that in habitual aggressives the abnormalities in the EGG are the result of disorder of these activating structures and only secondarily of neocortex. If this is the case, it remains to consider how this may relate to the uninhibited behavior which has caused the subjects' incarceration.

Is Celiac Disease a Clue to the Pathogenesis of Schizophrenia?

F. C. Dohan

Schizophrenia appears to occur more frequently in children and adults subject to celiac disease. Many clinical features are similar. Inherited susceptibility, probably polygenic, appears to be a necessary, but not sufficient, condition for the development of each. The environmental factors evoking the manifest disease are established, in part, for celiac disease (i.e., wheat gluten and similar substances in other grains), but not at all for schizophrenia. Perhaps this relationship to celiac disease is a clue to at least one facet of the pathogenesis of schizophrenia.

My purpose is to alert mental health workers to this probable relationship so that they may seek evidence of celiac disease in schizophrenic and autistic patients and their families.

Recognition of "possible celiac disease" during an episode with classic symptoms is easy. However, most children and adults do not exhibit the complete picture. The symptoms are those due to marked impairment of absorption of food from the intestines. The child is likely to be emaciated and to have a protruding relaxed abdomen; a wizened, unhappy face; frequent bowel movements; and secondary metabolic effects, such as low blood calcium and vitamin deficiencies. Specific diagnostic studies must, of course, be done since other diseases may have similar symptoms.

Patients with less severe celiac disease may have no diarrhea and mild evidence of malnutrition. It would be important to plot the height and weight of schizophrenic and autistic children on the pediatric growth chart.

Psychiatric symptoms are prominent in most children and in many adults with celiac disease. A number of investigators of celiac disease have noted mood and behavior changes in celiac patients relatively promptly after the administration of gluten proteins and improvement on omitting them from the diet.

The kind of mental stress exacerbating symptoms in celiac patients and schizophrenics may be similar. Other similarities include autonomic nervous system disturbances and the excretion of indoleacetic acid and 5-hydroxyindoleacetic acid in increased amounts by schizophrenics when symptoms are more severe than usual and by symptomatic celiac patients eating a gluten-containing diet.

If all traces of wheat, rye, barley, and oats are removed from the diet, a marked improvement, often to the point of apparently robust physical and mental health, almost always occurs in the celiac child and, somewhat less frequently, in adults. Weeks to months may be required. Reintroduction of these grains into the diet usually produces a relapse in days or months, sometimes in hours.

The noxious material is one or more of the polypeptides in the gluten proteins. Cow's milk proteins and other cereal grains may be harmful to some patients. The noxious effect is suspected to be due to either a direct toxic action or an immunologic mechanism.

Condensed with permission from *Mental Hygiene*, 53(4):525–529, 1969.

The evidence relating celiac disease and schizophrenia is based largely on clinical observations in the Philadelphia, New York, and Baltimore area. In a New York hospital, 11 of 32 adults with celiac disease were severely disturbed emotionally and three were considered to be schizophrenic. In a series of 12 adult celiac patients at the Hospital of the University of Pennsylvania, there was one with schizophrenia and another who had a schizophrenic daughter. Other students of celiac disease have reported an increased incidence of severely disturbed behavior, e.g., five "psychotics" among 94 patients in a study made at Mount Sinai Hospital in New York City.

Although little has been published by psychiatrists and other mental health workers on the frequency of celiac disease among schizophrenic children or adults, personal communications leave no doubt in my mind that the association of these two diseases is many times that expected by chance.

I am personally aware of six families in which one member has schizophrenia and a brother, sister, parent, or child is said to have, or have had, celiac disease. An investigation of the possibility that one or more genes are common to the two diseases would be warranted.

A careful personal and family history of a large number of schizophrenics and of autistic children in regard to celiac disease would be a valuable contribution.

There were some reports before the Second World War, when cereal grain consumption was considerably greater than at present, that suggested that cereal grains might play a role in the pathogenesis of schizophrenia. One investigator reported that the symptoms of tube-fed psychiatric patients, mostly catatonic schizophrenics, were identical with those of "endemic sprue" (celiac disease). There were reports of atrophic changes in the intestines of schizophrenics somewhat similar to those in celiac patients. Diarrhea was noted in 20 per cent of schizophrenics, but in only 1 per cent of non-schizophrenics; and an autopsy study indicated an apparently considerably increased frequency of celiac disease as a cause of death of schizophrenics.

My studies have demonstrated a high correlation between marked changes in wheat and rye consumption and equally marked changes in first admissions for schizophrenia in five countries during the Second World War. Preliminary studies indicate that relapsed schizophrenics randomly selected to receive a diet free of milk and cereal grains improved more rapidly than those on a relatively high cereal diet. Secret addition of gluten to the milk and cereal-free diet nullified this effect.

Although these studies appear to me to be encouraging, the contributions of many investigators will be necessary before they can be established as either a false or a fruitful lead.

Sweat in Schizophrenic Patients: Identification of the Odorous Substance

KATHLEEN SMITH, GEOFFREY F. THOMPSON, and HARRY D. KOSTER

The existence of a peculiar odor in sweat of schizophrenic patients was previously demonstrated when rats were trained to discriminate between sweat specimens of schizophrenics and controls; human beings were also able to discriminate between the sweat of patients and controls. We have now identified the odorous substance as *trans*-3-methyl-2-hexenoic acid.

Solubility studies of sweat specimens from patients with schizophrenia indicated that the odorous substance was a carboxylic acid. Programmed dual-column gas chromatographic analysis of the acidic components of sweat from seven schizophrenics and ten controls revealed an acid peculiar only to the schizophrenic specimens. The retention time of the acid was between that of *n*-heptenoic and *n*-octanoic acids, and about 0.1 μg of the acid per milliliter of sweat was estimated to be present in an average sweat specimen (about 100 ml) from a schizophrenic.

To obtain enough acid to elucidate its structure, the sweat specimens were acidified to pH 1, extracted with ether, dried over magnesium sulfate, and concentrated to 0.3 ml. Preparative gas chromatography of 13 samples afforded about 230 μg of the unknown acid.

The mass spectrum, infrared spectrum, and gas chromatographic retention time of the isolated acid were virtually identical with those of *trans*-3-methyl-2-hexenoic acid prepared by the dehydration and hydrolysis of ethyl-3-hydroxy-3-methyl-hexanoate.

The assignment of the *trans* configuration is based on the chemical shift of the allylic methyl protons. In β,β- dimethylacrylic acid, for example, the chemical shift of the methyl protons *cis* to the carboxyl group is 0.25 part per million downfield from the methyl protons *trans* to the carboxyl group. In the 3-methyl-2-hexenoic acid, the allylic methylene and allylic methyl protons have the same chemical shift because of deshielding of the allylic methyl protons by the carboxyl group.

Further confirmation of the location of the double bond in both the isolated and synthesized acids was obtained by cleavage of the unsaturated acids with alkaline permanganate to give 2-pentanone and by cleavage of the corresponding ozonides of the unsaturated acids with toluenesulfonic acid in ethanol to give diethyl oxalate.

Because the odorous substance is acidic, and because the only detectable difference in composition between the samples from schizophrenic patients and controls is the presence of *trans*-3-methyl-2-hexenoic acid, this acid is presumed to be responsible for the peculiar odor in the "sweat" of schizophrenic patients.

Crystals of this synthetic acid were added to "normal sweat" and a panel of four trained observers agreed that the odor produced was identical with the peculiar odor characteristics of the sweat of schizophrenic patients.

Condensed with permission from *Science*, 166 (No. 3903); 398–399, 1969.

Functional Versus Organic Diagnostic Problems

CHARLES E. GOSHEN

The outcry against costs of medical care demands attention at many different levels at which cost reductions might be effected. One area that could be streamlined is management of diagnostic problems in which there are questions of psychiatric disorder with or without organic conditions.

This study translates the hospital experiences of psychiatric and nonpsychiatric patients into data that reveal the practices of managing these patients when admitted on a medical or surgical service. The hospital was a 500-bed general hospital in a medical center which included a new medical school and an intern-residency program.

Three categories of patients were classified: patients who were found to have solely psychiatric problems (PSY group); patients who were found to have a significant medical and surgical problem and who, in addition, were found to have significant, diagnosable psychiatric problems (MIXD group); patients who were found to have significant medical or surgical problems but no psychiatric investigation or diagnosis (M-S group). The data were collected from hospital charts after patients' discharge from the hospital.

The numbers of patients for each group were: PSY group, 66, MIXD group, 35, and M-S group, 49. Correlations studies among the three groups were based on sex, age, length of stay in the hospital.

The diagnostic procedures were divided into laboratory procedures, X-rays, and special procedures, such as electrocardiograms, electroencephalograms, basal metabolic rate, and so on. The total number of each of the diagnostic procedures and the totals for each of the three groups were determined as an index of the variations in diagnostic approaches used by the staff for the three groups of patients.

To make estimates of the diagnostic thinking employed by the medical and surgical staffs in distinguishing the psychiatric from the medical-surgical problems, a classification of diagnostic procedures was established. The "metabolic category" was made up of those procedures which are thought of as indicators of metabolic disorders, such as glucose level, glucose tolerance, protein-bound iodine, iodine uptake, ketosteroids, basal metabolic rate, and so on. The "CNS category" are those procedures indicative of central nervous system function, such as skull X-rays, electroencephalograms, pneumoencephalogram, spinal fluid examination, and so on. Finally, the "aches and pains category" included tests, such as X-ray of spine, sinuses, abdomen, or gastrointestinal series, and so on.

Sex—The fact that the frequency of psychiatric problems among medical-surgical admissions is double in females as compared with males may indicate that: psychiatric difficulties are more common in females than in males; when psychiatric difficulties occur in females, they are more likely to be admitted for medical or surgical evaluation; or when functional rather than organic problems are found, females are more likely to be referred to the department of psychiatry.

Condensed with permission from the *New York State Journal of Medicine*, 69(17):2332–2338, 1969.

Although female psychiatric patients outnumber males in most treatment settings (except involuntary admissions to State hospitals) there is no reason to believe that females show a higher incidence than males. Instead, it appears that females are more likely to accept psychiatric referral, and physicians more likely to recommend it. In the psychiatric division of the hospital, made up chiefly of patients referred from the medical-surgical services, females outnumber males in both inpatient and outpatient services by four to one. Of the three explanations the third is considered most plausible, namely, that females are more likely to be referred to psychiatry when psychiatric problems are suspected. When psychiatric problems are found in males, the medical-surgical services are more likely to manage them by attempting to "prove" that there is nothing wrong than to consider the problem as suitable for psychiatric management.

Age—No significance can be attached to the distribution of ages for the three groups. The low number of older patients in the M-S group is not representative of the hospital population in general. The M-S group contained a larger number of the pediatric cases than did the two groups with psychiatric problems.

Length of hospitalization—In appraising hospital stay it is important to note that the number of hospital days for the two groups with psychiatric problems consisted of time spent on medical and surgical services, and there were no hospital days included for the psychiatric service. The PSY group incurred a length of stay nearly equal to that for the M-S group, but the former spent this time only for diagnostic purposes while the latter also spent their hospital time undergoing treatment. The hospital stay for the MIXD group was substantially longer than for either of the other two, indicating that the medical and surgical services found the diagnostic problems in such cases more baffling and the process of arriving at a diagnosis more complicated. It was the impression of the psychiatric service that patients who had both a medical and a psychiatric problem were sent for psychiatric consultation as a last resort. The purely psychiatric problems were more likely to have the diagnostic procedures and referral to psychiatry speeded up. Termination of hospital stay tended to occur immediately after a psychiatric diagnosis was made, so that longer stays were associated with the process of postponing psychiatric referral.

Costs—Costs included hospital per diem charges and cost of diagnostic procedures, but not physicians' charges. Most significant is the observation that it costs 20 to 25 percent more to find out that a patient has both a medical and a psychiatric condition than if only one of the two is investigated, even though the process of investigation is the same. The medical tradition whereby students are taught to seek single rather than multiple diagnostic explanations for clinical conditions probably is related to the tendency to postpone decisions and increase the cost, when two phenomena are present.

Diagnostic procedures—The number per patient of diagnostic procedures performed on the three groups shows that the solely psychiatric patients had an average of 15 and the other two groups an average of 20 different diagnostic tests. The mixed

group, although having the longest length of hospital stay, did not have any more diagnostic tests than the medical-surgical group.

The classification scheme suggests that physicians who assume that functional problems have a metabolic basis are likely to ask for tests of metabolic function, while those who see central nervous system disorders as the basis for psychological problems tend to ask for tests of the central nervous system function, and those who approach functional problems by investigating each complaint of aches and pains of the patient are likely to ask for a type of test which might reveal disorders productive of aches and pains, such as X-rays of abdomen and back. It would appear that the less some kind of disorder is apt to occur, the more frequently is it investigated. Not infrequently, tests are performed not because the physician expects to find evidence of disease but to provide him with evidence to "prove" to the patient that "nothing is wrong." Probably no philosophy of management of psychiatric problems is more prevalent among non-psychiatric physicians than this one. The very large variety of procedures performed in the PSY and MIXD groups indicates a lack of coherent policy in the type of diagnostic approach to psychiatric problems.

The most significant conclusions to be drawn from this study are those which apply to medical education rather than to economics. There appears to be an ingredient missing in medical training, the teaching of valid criteria for the detection of the state of illness as opposed to the state of good health. Whether the most reliable criteria are based on clinical judgment acquired from experience or on a particular assortment of diagnostic tests, it is obvious that the mere complaints offered by patients are poor indicators of illness and should be regarded as having little significance except for their role in bringing the patient to medical attention.

Complaints indicate the presence of a state of dissatisfaction, but illness is only one possible cause of such a state. In spite of the sophistication in the design and performance of diagnostic tests, there seem to be little confidence in their usefulness in measuring good health and little interest in the design of new tools for ascertaining the state of good health. The psychiatric euphemism of "mental illness" contributes to the confusion by implying illness when, in fact, psychological problems are at stake. Another self-defeating trend is the management of functional problems by attempts to prove nothing is wrong, which often has the effect of forcing the patient to develop new complaints, leading to additional diagnostic procedures.

Mental Health Consultation and Sector Psychotherapy

ERNEST W. FERNEAU, JR. and DONALD C. KLEIN

We have been struck by similarities between sector psychotherapy and crisis consultation and believe it would be valuable to compare them.

One reason for the evolution of the role of the mental health professional is economic. There are not enough workers to meet demands. Both consultation and sector psychotherapy are, in part, responses to the economic problems, which promise to continue for many years. They both seek to influence the greatest number in the most efficient way within the time limitations imposed by reality.

Sector psychotherapy was first seen as the method-of-choice with psychosomatic conditions. This method is a refinement of the minimal interference techniques associated with the psychoanalytic approach. It arose in 1942 because of demands occasioned by the war and had its origin in a certain type of interviewing technique (associative anamnesis). Sector psychotherapy is an effort to induce the patient to indulge in a freer kind of thought production without awareness of it, to "bypass" defenses.

Sector psychotherapy is appropriate for use with most hospitalized patients, in view of the limited amount of therapeutic time made available by the shortness of the hospitalization, and the state of the patient's ego, the technique's accent being on ego integration and conscious control. Its relative simplicity facilitates its use by many tyros. Indeed, both mental health consultation and sector therapy stress the use of simple, definite guiding principles, an adherence to a structured method of approach, and the continuity and interrelationships of the interview. The therapist uses the technique to aid in controlling *his* unconscious (another economic factor), which may influence, e.g., the total number of contacts.

One approach to mental health consultation is based upon a psychoanalytically oriented, homeostatic view of mental health. The individual is usually in a state of equilibrium and attempting to maintain it. When such attempts are unsuccessful, the individual is "in crisis." Crisis is an acute phenomenon, and eventually the person reaches a new stable state which may be at a point on his psychological life scale that is less healthy than his precrisis point. During crisis, only minimal intervention is needed to tip the scale the other way.

Mental health consultation is an effort to promote a more efficacious functioning in care-taking agents (consultees), helping them to tip the balance in the health direction with clients in crisis. The agents may be teachers, and the clients, their pupils. The consultation is a personal interaction between two professionals in which the consultant attempts to reach his goal within the ordinary structure of the consultee's work environment. The latter retains the case responsibility. Another aim is that the consultee learn to deal more effectively with the problems he presents at any one point in time.

The nature of both processes demands that the interaction be more on a discussion basis between two collaborators than on a directive basis with the therapist acting as a blank screen.

Condensed with permission from the *Psychoanalytic Review,* 56(2):327–339, 1969.

The initial focus—Both consultant and therapist focus on creating the proper working relationship; the relationship is "built up" during the first few interviews. Both manipulate the timing as well as emphasize the importance of spacing and length of contacts to avoid undue dependence, while attempting to maintain sufficient motivation, anxiety, and tension to produce movement and yet not so much as to "panic" the other. Consultant visits are typically spaced two or more weeks apart, and are usually few in number.

Both recognize the help-seeker's initial fear of the helper as a "destroyer of defenses"—an anxiety which must be dealt with early in the relationship. One way is to avoid premature interpretations.

Goals—The major goals in both systems are changes in both the value (attitude) and behavorial (symptom) complexes of the one who seeks help. The consultee as well as the patient (as, indeed, all of us) has told himself a "pat story," an oversimplified, innocuous explanation of the situation for which he seeks help —in the service either of his dynamic needs (e.g., to protect his self-esteem) or his cognitive ones (e.g., to at least achieve an "explanation," in order to avoid undue complexity or ambiguity and more generally to conserve energy). In sector psychotherapy the "pat story," as a defense, must be broken up and increasingly fragmented. The patient communicates with "prelogical fantasies." It is another aspect of the "indirection" similarity that neither the "sector therapist" nor the consultant works to increase the insight or cognitive clarity of the patient or consultee. In sector therapy, one attempts with guided associations and reiteration of "key words" to break up the patient's old gestalts, to differentiate and to reintegrate, to break up the old neurotic links and to aid the establishing of new, more realistic ones. More positively stated, one aims to introduce healthier links and balance between defenses and adaptive processes, needs and impulses, and environmental demands.

Both therapist and consultant also are "facilitators" in that neither tends to answer the direct question, viewing such as either a trap or an evasion, and believing the act of answering to be "countertherapeutic." Both see it as much more profitable if the change-seeker finds the answer within himself.

Both seek their goals by implication and indirection; each tends to use a limited sector approach to render the interfering displacements impotent. Just as the consultee may displace his conflict and anxiety onto a client-system-linked problem, so too the patient may displace (in whole or in part) to his body, to objects, to persons, etc.

Techniques—Both approaches share many measures and techniques designed to produce certain material and utilize it. While both methods gain some of their efficacy from the prestige factor, they also both use suggestion directly or indirectly. Both stress that the desire to learn should be promoted. Both use reinforcement of a patient's insight, or of a new, more desirable linkage. Both use abreaction, manipulation (indirect), clarification, confrontation, and interpretation. Both deal with the help-seeker's story as fantasy, as a "projection" and a displacement. Both stress that direct use of reassurance is to be avoided because it is ego-

weakening. However, support as needed is a fundamental aspect of both. Both emphasize the building of the relationship and the need for the helper's activity.

The review, the relationship-building, and the maintenance of the focus on the chosen track are fostered in sector psychotherapy particularly by word reverberation and a continued resetting of these key words. It is a prime factor in inducing and maintaining the positive transference state, a must in sector psychotherapy.

Structure and the help-seekers—Both methods may be viewed as having similar structural characteristics. It is an essential aspect of sector therapy that an ego split be promoted in the patient. In a sense, the portion of the ego that is the healthy, adult portion is the consultee; the "inefficient," "sick," child element is the client.

In mental health consultation, the consultee (e.g., a teacher) is aided in examining alternative ways of relating to her client (e.g., a student) whom she feels is "beyond help." In sector therapy, the patient's approaches (fantasies) to his presenting symptom (the sector of choice) are explored as alternatives (the expected future). In neither circumstance are the dynamics of the one seeking help the direct subject of discussion, and while the transference is observed and utilized, it is rarely analyzed. It is a dictum in sector therapy that only one symptom/syndrome/sector is taken at a time; and in crisis consultation, that the focus remain on the particular theme interference.

Structure and the relationship—It is the benevolent aspect of the therapist that fulfills the patient's expectation of receiving help. It contributes to the atmosphere of trust that leads to positive results via a positive transference state.

The detached element of the therapist or consultant fulfills the expectation that he will be understanding as well as benevolent. These perceptions make possible the constructive use of dependency in both relationships. The therapist and consultant enhance these perceptions by standard procedures. The therapist is advised to pay attention to the subject's language and to respond at the same level. He avoids interrupting and excessive note-taking; he adapts his posture to that of the other. He maintains eye contact and reveals interest by posture, facial expression, and similar cues.

For the consultant, the benevolent part must "go beyond" objectivity also. Benevolence and "technique" are necessary but not sufficient conditions for successful consultation. The consultant must understand and empathize with the work role and context of the consultee, to the point of "becoming" an educator, learning the language of the clergyman, etc.

Both consultant and "sector psychotherapist" must assume the role of a supplementary ego and an ego-ideal figure (as well as a supplementary super-ego in some respects). Both the consultant and the therapist serve as an important role model to the consultee or patient.

Both systems emphasize that ultimate responsibility must remain in the change-seeker's own hands. Then, for example, the "open-door policy" is seen by patient or consultee as mainly his choice and his decision (provided there is a successful working-through of the problem).

Both are "goal-limited," but also see secondary future positive effects occurring besides those directly and "immediately" intended—somewhat of a pebble-in-the-pond effect. And both patient and consultee, as they try new alternatives and experience "success," further benefit from this feedback and gain an increased sense of competence.

Both stress a scientific approach insofar as one aspect of it is constant hypothesis-testing, and both are led by theory. Both types of helpers are enjoined to be active in continually forming hypotheses about the dynamics of the change-seeker, the helping process, and the problem, in guiding discussion around these probabilities and testing them, and revising them as frequently as necessary.

There are several dissimilarities other than the fact that one is psychotherapy while the other is consultation. The therapist is concerned with helping the patient to solve *personal* problems, while the consultant attempts to aid the consultee to solve *work* problems.

Unlike crisis consultation, sector psychotherapy attempts to facilitate insight to the degree that the patient experiences a greater freedom of choice in relation to that "sick" part of him. It is a constant admonishment in sector therapy that the therapist should never let the patient know what the former wants or is doing; an obvious technique is not a good one because there is a high probability that the patient would isolate the sessions, use material and themes as defenses, and appear to have insight when he does not.

Finally, sector therapy requires a push into the patient's past, whereas to take an analogous tack in consultation would vitiate its goals.

The relationship—We also see aspects of one system which may help to suggest new facets and emphasis for the other. Elements from sector therapy may help the consultant avoid doing psychotherapy. Development of a trusting, collaborative relationship is the first task of the consultant. Sector therapy suggests ways it can be done. Consultants may also profit from adhering to the "key word" concept. Key words are those which when repeated usually "lead" in the direction of the most information concerning the patients' difficulty. They are also used to aid in building the relationship. Greater utilization of this approach by consultants may be one way of reducing complaints by consultees that "he (the consultant) doesn't even understand the problem."

Associative emphasis—Consultation might also profit from a greater effort to utilize associative exploration and to follow the sector therapist in a continued re-setting of key words (word reverberation): to stimulate greater production, to investigate areas of affect and to create affect, to aid in achieving and maintaining the positive transference state, and to facilitate the integration of the interview, the relationship, and the change-seeker.

Further Exploration of Unilateral Electroshock Treatment

PANG L. MAN and BYRON J. BOLIN

Electroshock therapy still holds a secure place as a useful psychiatric treatment. Psychoactive drugs have reduced but not eliminated its usefulness. Standard bilateral EST has at least one serious drawback, that of temporary disability in cognitive functions.

Modification of conventional EST to the unilateral form is based upon the fact that with most persons the left or right hemisphere is dominant. The results of several studies support the aim of unilateral EST: to minimize possible brain damage by avoiding as much as possible undesirable residual effects upon the dominant hemisphere and its many adaptive functions. The present study is intended to add to evidence on the matter.

The subjects represent a small fraction of the total admissions to the intensive treatment service of a 950-bed State hospital.

One of the following clusters of symptoms predominated in the total symptom-picture of each patient: *depressive,* with such features as low mood, moderate or marked psychomotor retardation, loss of appetite, weight loss, suicidal rumination or suicidal attempt, feelings of guilt or worthlessness; actively psychotic, *chronic schizophrenic* with such features as confusion of thinking, tumultuous emotions, inappropriate affect, autism or withdrawal, looseness of associations, delusions and hallucinations.

Of the 23 schizophrenics, eight were catatonic, five schizo-affective, and 10 of other types. Of the 17 depressives, five were manic-depressive depressed; eight were involutional depressions, and four, psychotic depressive reactions. There were 17 men and 23 women; ages ranged from 18 to 57 years with an average of 35.2. Each patient received an average of 8.2 ECTs.

In the depressives, tricyclic antidepressants, sometimes given with phenothiazines, had brought either no improvement or worsening. The schizophrenics had failed to respond to phenothiazines.

Dominance of hemisphere was determined by testing for sidedness of hand, leg, and eye, with right-handedness implying left-sided hemispheric dominance. We planned to test all the patients before and after the course of EST to see if there was any change in major cognitive function of the patients. Only 16 patients were well enough to complete the tasks. After treatment, the patients received psychiatric assessment of change in terms of: worse, no change, mild improvement, moderate improvement, marked improvement.

All patients in the depressive group showed improvement; 11 showed marked improvement, five were moderately improved, and one was mildly improved.

The eight catatonic schizophrenic patients recovered completely from the catatonic state. Five showed marked total improvement while three improved moderately in the general symptom-picture. Of the five schizo-affective schizophrenics, three recovered from the depressive features, the two others showed no change. Six of the 10 patients repre-

Condensed with permission from *Diseases of the Nervous System,* 30(8):547–551, 1969.

senting other schizophrenic types showed considerable improvement, including disappearance of agitation. Four who remained unimproved were resistant to all kinds of treatment.

Among the areas of cognitive functioning sensitive to organic impairment are recent memory, abstract thinking, visual-perceptual-motor functions, and ability to retain. The test for recent memory consisted of eight questions concerning highly publicized information during the past few years. The first six items of the Wechsler-Bellevue Similarities subscale tested abstract thinking. Visual-perceptual-motor functions were tested by the Bender Gestalt test scored for such faults as loss of configuration, perseveration, alteration of angles. Retention ability was tested by the Revised Benton Visual Retention test.

Sixteen patients served as subjects for psychological evaluation. They had an average age of 37.8 years (range, 18 to 56 years). They fell into diagnostic groups: schizophrenia, chronic undifferentiated with active symptoms, five; schizophrenia with catatonic features, two; psychotic depression, eight; severe neurotic depression, one.

Each subject received the tests the day before commencement of EST, and six to 12 hours after the last application in the series. The patients had received from five to 14 treatments, with an average of 7.6.

The average score on the recent memory was 5.1 items before EST and 6.2 items after the treatment, and on Similarities it was 5.8 before and 7.4 after. Error points on the Bender Gestalt test averaged 16.5 before and 10.8 after treatment. On the retention test, the average score before treatment was 2.4 and 4.2 after.

These scores might imply that a course of unilateral electroshock therapy leaves no impairment in functions known to be sensitive to various kinds of brain damage. No such inference is drawn here.

At the outset, the data from most of these patients indicated some cognitive impairment. Thus it is uncertain how often initial scores represent normal base levels in the functions tested. Some impairment could have been left by the EST simultaneously with relieving pathological hindrances to the functions concerned. But the results favor the likelihood that the subjects' cognitive deficits were no worse at the end of the treatment than at the beginning.

Certain observations are noteworthy. During part of the study some patients were receiving bilateral ECT while our subjects were receiving unilateral treatment. The unilaterally treated patients awoke first and showed less confusion.

Patients made little complaint about headaches and forgetfulness after unilateral treatment. Few resisted unilateral EST, whereas patients' efforts to avoid bilateral treatment are common knowledge.

Formerly, several beds were required in the EST treatment section to accommodate patients, watched by a nurse, as they recovered from treatment. Unilateral application has made this arrangement unnecessary; patients sit or recline for five to 10 minutes and are then escorted to the ward.

Ministry in a Comprehensive Community Mental Health Center

ROBERT J. CARLSON

This paper will include illustrations and generalizations that grow out of my experiences as staff clergyman at Prairie View, a comprehensive community mental health center in Newton, Kansas. Begun as a private psychiatric hospital under the auspices of the Mennonite churches, Prairie View has for the past eight years contracted to provide community mental health services for a three-county area in Kansas. It provides inpatient care, a day hospital, and an outpatient program. An extensive program of community services is in operation providing consultation, education and family life services to the schools, courts, welfare offices, police, pastors, etc.

The catchment area is primarily agricultural though the majority of the residents live in towns. Newton has a population of 16,000 and several small industries including the railroad and mobile home factories. Nearby Hesston has a large farm machinery manufacturing plant. There is a wide variety of churches and most people maintain church affiliation.

As I tried to find a parallel pattern for the ministry that has evolved in this center I found myself going backward through the Biblical tradition considering and discarding Paul, Jesus, Amos, Isaiah, Moses, and Abraham.

Then I wondered about Moses. He was a law-giver, organizer, and a patriarch of a new cultus. I think I would rather let Moses and the wandering Hebrews represent the development of the mental health worker in community services and look elsewhere for a model-bearer. I would commend the model of Jethro, a priest of Midian and father-in-law of Moses.

Jethro was a priest, experienced in religious ritual and in dealing with people. Moses met him when he fled following his killing of an Egyptian. During the last century there has been a thesis that the cultic tradition of the Hebrew community was derived from the Kenite clan of Midianites to which Jethro belonged. Yahweh may have been originally the god of this district near Mt. Saini; Moses may have learned of this god from his father-in-law. When Moses returned with the fleeing children of Israel, Jethro came again to instruct him in the ancient lore of religious ritual and to make him also a priest of Yahweh.

If you will allow me to represent the mental health worker as Moses suddenly surrounded with a community of needy people who come to him with concerns, the staff clergyman may then see in Jethro a parallel to himself. He represents a ritual and tradition of considerable historical origin which has some sensible suggestions to the mental health worker about how to go about the task. Moses' skill and leadership and Jethro's experience and authority made a pretty good combination.

The purpose of this exercise in looking for Biblical parallels is to identify the interplay between the two establishment forces—the church and the mental health facility. Both are faced with a new wilderness, the

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Condensed with permission from *AMHC Newsletter*, 22(1):25–32, 1969.

wilderness of community, a place in which the mental health practitioner has felt estranged and uncertain. Like Moses he was used to dealing with individual cases as they came. Suddenly overwhelmed by the massiveness of the task, he is faced with finding new ways of dealing with individual needs including some common understandable instructions and the development of additional persons to help carry the load of counseling.

Staff clergyman in the community mental health center must seek to serve two agents: the mental health practitioner himself and the community. At the same time he must recognize that his roots are in a separate establishment and tradition, and that his ministry must be seen as dependent upon the continued existence of the religious establishment. One principle of a community mental health center is that the center is to urge and stimulate the community to locate, develop, and apportion resources to meet the mental health needs of its members. The task of the staff clergyman is to work with the mental health team in helping the community to take responsibility for its own needs.

In Newton a committee of community people began to meet to look at the function of needs and supplies. They recognized the dearth of qualified leadership. Two members of the community mental health center staff, two industrialists, a city manager, an assistant superintendent of schools, a clergyman and a college president participated in the meetings. During the current year they have organized under the title "Leadership, Inc.," (LINC) and have sponsored three leadership training laboratories in which a cross section of community persons have shared in workshops designed to foster cooperation, interagency understanding and development of leadership skills.

The community mental health center served as a stimulus to begin the organization. The LINC committee has its autonomy, sponsors its events, functions with a constitution and board separate from the administrative structure of the mental health center. The staff clergyman needs to follow this method of collaboration in his ministry.

Another principle is that the community mental health center should make professional resources available to the self-identified needs of the community groups. When community needs are expressed, the center needs to find ways to make its expertise available.

A clergyman on the board of the Reno County Mental Health Association called the chaplain to discuss a proposed sex and family life education conference. He was referred to the family life educator on the staff. A special series entitled "Project Responsibility" was planned in cooperation with the churches of Hutchinson. Publicity was handled by the Mental Health Association. Objectives, format, and personnel were determined by a committee of young people and adults from Hutchinson. Three persons of the center staff took part in the three Sunday evening workshops. The family life educator met each week with the junior high young people. The chief social worker met with the senior highs. The staff clergyman met with the adults. In each case there was a presentation followed by small group discussion led by Hutchinson people.

The clergyman trained in evangelism sometimes needs to caution himself against providing "supplies" for those who aren't asking.

The community mental health center should plan to receive community feedback. The staff clergyman needs to be aware that he has a good deal to learn from the community itself. The mental health center represents the establishment and, as such, is afflicted with the myopia of the middle class. Consumer participation in informal feedback structures and in direct involvement in policy-making boards is necessary. Part of the ministry of the staff clergyman is to help his team be responsive to the community's messages to the professional in the establishment, particularly as they come through the churches.

The day-to-day task of a staff clergyman may take many forms. The following illustrates possibilities:

Consultant to pastors

Outpatient counselor

Liaison with pastors

A community enabler—to enable community agents to look more realistically at the possibilities the church offers for supportive mental health and personal resources.

An organizer for the creative and developing program of the church. The clergyman encourages the development of organizations dedicated to healthy religion programs.

A staff resource for broad literature and experience in values, church renewal, and religious support.

Leader in responding to the needs of the indigenous community. The staff clergyman of the mental health center may know of the vacancies on the boards of OEO planning groups, community action programs, etc.

Clinical pastoral educator. The patterns that form in the ministry need to be geared not so much to the model of the inpatient program but to the activity of community services in education, consultation, and the other forms of prevention.

In many programs an adequate financial base has not been established. Clergymen salaried by the State for work with inpatients as a "captive community" have frequently avoided discussing the fee for service. Often target groups (like churches) have other religious resources available (their own pastors). They are therefore not prepared to pay for services of a specially trained mental health center clergyman. An important principle is that the cost of such services be shared by a supporting institution (such as the government) and by the recipients of the service.

As the community mental health center makes professional resources available, it will involve the staff clergyman in that task. He needs to be a part of the team trained to speak to the responsible issues of our time, particularly those which contribute to mental health and appropriate moral standards. A risk is involved in that he must deal with people across a wide range of denominational and creedal commitments. He cannot expect to avoid theological offense at all times but he must try to keep his particular theological bent from standing in the way of communicating an appropriate health message.

Social Restoration of Hospitalized Psychiatric Patients Through a Program of Special Employment in Industry

ROBERT WALKER, WILLIAM WINICK, EARL S. FROST, and J. M. LIEBERMAN

According to the president of a large American corporation a movement has developed in industry emphasizing product and service along with profits. It is becoming less acceptable for a company to boast that it is in business solely to make a profit.

Concomitant with this change has been a sharp upturn in industrial activity with a resulting increase in competition for a shrinking labor market in certain parts of the country and especially in the area surrounding our hospital. In 1961 we began a program known as Community Hospital Industrial Rehabilitation Placement (CHIRP).

It was felt that many psychiatric patients could be helped to greater service in the community if they had the chance to be productive citizens despite their needing to be hospitalized over varying periods for mental illness. Unlike many forms of sheltered employment, CHIRP reimbursed patients at the standard rates of pay prevailing in private industry. In no case was the rate less than the Federal minimum wage, although the total number of hours worked per week per patient was (and continues to be) less than 40.

The growth of CHIRP was given impetus by coincidence involving an accident in the warehouse of a nearby plant, which necessitated a large amount of temporary labor shortly after the hospital had begun seeking its first group of subcontracts.

Another circumstance led to the development of Community CHIRP. A plant needed 20 people to inspect products on a contract that had to be completed in a hurry and could not be accomplished outside the factory for security reasons. The company furnished a bus to transport CHIRP patients to the factory for a six-week period. It worked so well that it has continued—and expanded—ever since. Several other firms in the area have adopted similar programs as part of their production policy, including a large insurance company.

All CHIRP activities are medically prescribed by the patient's ward physician in consultation with a physiatrist. Community CHIRP consists of placement of certain patients in a regular industrial setting off the hospital grounds. Supervision provided by the industry is supplemented by rehabilitation staff of the hospital who is in contact with each patient daily, working in close association with the plant foremen.

The hospital assumes responsibility for the transportation of all hospitalized Community CHIRP patients and also transports many Community CHIRP outpatients who work other than the daytime shift. Since most factories are 30 to 50 miles from the hospital, car pools have been formed and provide a spontaneous and natural group, with the therapist accepted as a member. Personnel problems are handled by the rehabilitation worker rather than by the plant foreman and tend to be managed on an informal, perhaps more supportive, basis than could be provided in tra-

Condensed with permission from *Rehabilitation Literature*, 30(10):297–303, 1969.

ditional hospital or posthospital settings.

All payments are deposited in the patient's account in the hospital. Withdrawals in the case of inpatients are made only on written authority by the patient's physician. Outpatients control their own funds.

We decided to build in an evaluation procedure on a small sample of future openings. Over a nine-month period, 14 openings that could be evaluated for special patient employees developed in the Community CHIRP program. Volunteers were solicited from patients active in Hospital CHIRP. The patient had to be recommended by the manual arts therapist as to satisfactory work ability and then cleared for Community CHIRP by his ward physician. Out of a cohort of 28 eligible patients, 14 were selected randomly to become experimental patients; the remaining 14 served as controls.

Eligibility for Community CHIRP was determined by: successful Hospital CHIRP experience of at least two full working weeks immediately prior to selection; recommendation of the patient by his Hospital CHIRP work supervisor (rehabilitation therapist); willingness of the patient to volunteer for Community CHIRP; clearance by the patient's staff physician for off-grounds rehabilitation

Follow-up of both experimentals and controls was carried out for six months, beginning with the day the experimental patient first reported to his Community CHIRP job.

Although we were concerned over the possibility of acting-out behavior or other psychiatric symptomatology during the working day that might jeopardize the program, no such incidents took place. While some patients were actively psychotic and the illnesses of others were exacerbated as measured by rehospitalization, at no time did a firm report any undue difficulty with an experimental patient. According to the initial evaluation of the Hospital CHIRP rehabilitation therapist, only four of the 14 experimental patients were manifesting overt signs of psychosis at the end of their Hospital CHIRP experience. The plant foremen, on the other hand, were aware that most candidates were inhospital patients at the start of Community CHIRP. Presumably, they expected deviant behavior.

A behavior rating scale was devised to estimate readiness for Community CHIRP. The rehabilitation therapist who was the patient's work supervisor in CHIRP made the ratings prior to the evaluation period without knowledge as to whether the patient would be included in the experimental or control group.

The patients who later became the experimentals did not differ significantly in potential for the Factory CHIRP program at the time of selection.

Earnings over the two weeks prior to the study were almost identical between the two groups. These two measures of readiness indicate that the random selection yielded comparable groups of patients.

The main question investigated was: Given an employment opportunity similar to a regular job (except for the special supervision and method of payment), would the experimental patients more nearly approximate a normal employment record than the controls? Second, what effect would this employment exert on the psychiatric status of the experimental patient as measured by

amount of hospitalization over the six-month period?

A mail follow-up was utilized for learning the outcome on patients who left CHIRP. When necessary, telephone contact with the patient or with his next of kin supplemented mail follow-up. Hospitalization and employment outcome were obtained on all 28 patients.

The experimental and control patients continued to receive the same psychiatric treatment that they were receiving prior to the study. They were discharged from the hospital or outpatient status—or not—as decided by their physicians. Independently of the study, both groups received extramural therapeutic contacts as recommended by the physician. The exception to this rule was assignment to Community CHIRP; only the experimentals had participated in this special work experience.

A comparison of the two groups in respect to established diagnosis revealed essential comparability. The condition of 50 percent of the patients in both samples was diagnosed as schizophrenic.

The experimentals came closer to working a normal work week than did the controls. However, identical proportions of the patients from each group obtained regular competitive employment.

Patients in both groups were free to secure regular employment during the study period or to continue in at least one form of CHIRP as long as they wished and as long as they maintained a satisfactory degree of productivity. Consequently, full employment was theoretically possible for both groups. Defining full employment as working for pay for an average of at least 30 hours per week over the 26-week follow-up period, only six of the 14 experimentals and three of the 14 controls qualified as fully employed.

It is apparent that, when the patients worked at all, the experimental group tended to spend slightly more hours per week in employment than the controls. Also, on the average, the experimental patients apparently had somewhat briefer experiences than the controls with periods of total unemployment over the six months.

Using nights spent in the hospital over the six-month evaluation period as the criterion of hospitalization outcome, almost identical hospital usage was found for the experimentals and controls.

It is not surprising that considerable unemployment and underemployment of the severely mentally ill persists even after hospital treatment. What is surprising is that so many patients continue to be discharged without follow-up or post-hospital care in the area of employment/reemployment.

Our findings suggest that greater proportions of hospitalized psychiatric patients can be restored to useful employment status than appears to be happening in most psychiatric hospital settings in this country. Widespread development of special employment services and facilities on and off the hospital grounds, combined with sheltered living arrangements in the community and other aftercare services should reduce the mental hospital's role as a home for dependent adults and enable it to serve its functions of diagnosis and treatment.

The Lincolnshire Rehabilitation Scheme

J. H. Price, F. A. Bleaden, J. D. Thomas, and D. Kerridge

The scheme which is the subject of this report was designed to show that chronic mental patients can achieve successful rehabilitation outside the hospital. It was instituted by St. John's Hospital, Lincoln, and the firm of Richard Thomas and Baldwin at their Redbourn Works at Scunthorpe. Employment was made possible by the cooperation of the patients themselves, the community, the works management, the trade unions, the works medical department, and the hospital staff.

Selection of patients was made on the basis of their ability to undertake employment in the hospital, and work in occupation therapy centers, various departments, and the industrial rehabilitation unit.

The patients were employed in 23 types of work ranging from a graduate process chemist to janitors. As the majority had not received an approved training, they had to be employed as laborers. Twenty St. John's patients, 18 from Saxondale and five from Rauceby were employed in the blast furnaces. Only three patients had to be moved from their first placing. This indicates the adaptability of the patients and the efficiency with which the Industrial Labour Officer and the Hospital Rehabilitation Officer were able to select the patients.

Results show that 65 percent of the patients have worked more than a year. The crucial factor in their successful rehabilitation is not merely the training, but rather the skilled supervision which they receive at the Works—supervision which covers not only their occupations, but also their social and medical lives. This supervision is an extension of that provided in the hospital itself, where the patients work in an industrial rehabilitation unit.

As they gained economic independence, the patients gained confidence, improved their personal appearance and eventually lost all semblance of institutionalization, such as walking in "crocodiles" or standing about aimlessly.

The main problems in establishing a rehabilitation scheme of this type are:

The importance of treating the patient's illnesses and then stabilizing them.

The avoidance of stagnation among both patients and staff in the hospital.

The careful selection of key personnel who will work the scheme, particularly the hospital rehabilitation officer.

Comprehensive aftercare for the patients in the outpatient department and by the general practitioner.

The acceptance of the hospital patient by his fellow workers.

The active acceptance by the management of the patients' economic contribution.

The full understanding and cooperation of the works medical service.

Provision and supervision of transport and accommodation.

Condensed with permission from the *British Journal of Psychiatry*, 115 (No. 526):1043–1048, 1969.

Mental Health and the Law

Recent Cases

The Supreme Court began its new term early in October with several cases of mental health significance on the docket. One of the cases that will come before the Court will involve the issue of whether the police can ever constitutionally arrest narcotic addicts "on suspicion" in the course of murder investigations. The appeal tests the conviction of Melvin Morales, an addict convicted of the murder of a Bronx woman in 1964. The police demonstrated painstaking ingenuity in solving the crime, but they seemed clearly to have violated the Fourth Amendment when they took Morales to the stationhouse "on suspicion" and obtained a confession. The Court of Appeals, New York's highest court, conceded this, but upheld the conviction anyway on the theory that under such circumstances the police had acted reasonably.

The Court will also decide criminal appeals in cases testing the constitutionality of provisions of Federal narcotics law. Another appeal challenges the authority of the State of Nebraska to sterilize mentally defective patients, but this case may be dropped because the law has been repealed. Other cases involving issues of mental health relevance are certain to be docketed shortly and decided in the current term.

Proctor v. Harris, U. S. Court of Appeals for the the District of Columbia Circuit, April 29, 1969

Appellant Proctor, confined to Saint Elizabeths Hospital pursuant to a commitment following a verdict of not guilty by reason of insanity, filed a petition for a writ of habeas corpus, alleging he had recovered, was not dangerous, and was eligible for release. He requested an independent psychiatric examination, contending that he had been confined for more than nine months and had not received an independent examination. Appellee Harris, the then Acting Superintendent, responded that Saint Elizabeths staff were of the opinion that Proctor had not recovered, and they could not certify that he would not be dangerous to himself or to others within the forseeable future if released. The District Court then ordered the Legal Psychiatric Service to examine appellant and render a report. This report stated that Proctor has not recovered and "could be dangerous to himself and others if released . . . at the present time." At the hearing, a psychiatrist from the Legal Psychiatric Service and a staff psychiatrist at the Hospital agreed that while appellant's mental condition was substantially in remission, he remained potentially dangerous. The Court thereupon discharged the writ.

On appeal to the Court of Appeals, the appellant challenged the present procedure which provides for an independent, non-partisan psychiatric examination by the Legal Psychiatric Service. He asserted that he, an involuntary indigent patient seeking release by habeas corpus, could not receive adequate independent psychiatric assistance in prosecuting his case unless he had the assistance of a "friendly" expert, a psychiatrist who would tell him what he wanted to hear and then guide his lawyer in how to conduct cross-examination of the hospital psychiatrist so as to neutralize their testimony. The court affirmed the decision of the court below, deny-

ing appellant his release, finding that the appellant is not entitled to government funds to shop for a psychiatrist sympathetic with his position. "Neither sound administration, basic fairness, nor constitutional standards require such a course," wrote Judge Burger, who was joined by Judge Danaher. The court noted, by way of dictum, that "[t]he situation would be entirely different if Appellant had been denied a meaningful hearing where he could be present with counsel, have an opportunity to be heard, be confronted with witnesses against him, have the right to cross-examine, and to offer evidence of his own."

Judge Bazelon, while concurring in the result, based his decision on the fact that "the record in this case does not demonstrate that the appointed psychiatrist . . . refused to cooperate with the appointed counsel for the appellant. Consequently, I cannot conclude that the appellant has shown a denial of the sort of psychiatric assistance in the preparation of his case to which he is entitled." Giving more weight than did the other judges to the merit of appellant's argument, Judge Bazelon noted that "[t]he central tenet of the adversarial process is that each side should attempt to 'neutralize' the evidence of the other side"; and he recalled "the difficulty a lawyer untutored in the arcane mysteries of psychiatry may encounter when appointed to represent an indigent who is mentally disturbed"; but he thought that an independent psychiatrist could properly and sufficiently "advise an attorney of the nature of his indigent client's mental abnormalities, the degree of uncertainty surrounding diagnoses of this sort of illness, and the lines of inquiry which might best help his client."

Commonwealth v. Wiseman, Supreme Judicial Court of Massachusetts, June 24, 1969; 38 L.W. 2036

The film "Titicut Follies" was made at the Massachusetts Correctional Institution at Bridgewater, to which mentally ill persons charged with crime and defective delinquents are committed. Permission to make the film was granted in 1966, subject to the conditions that the film's director would photograph only inmates who signed releases and who were legally competent to sign them, and that the film would not be released without having first been approved by the State Commissioner of Correction and the Superintendent of the institution.

After the film was made and shown to the Superintendent and to the Massachusetts Attorney General, the latter notified the producer, Wiseman, that the film constituted an invasion of privacy, that any releases obtained from the patients were not valid, and that the film therefore could not be shown. Wiseman then made an agreement with Grove Press for distribution of the film for showing to the general public; and the film was shown publicly in New York City. The Commonwealth of Massachusetts sought to have Grove Press enjoined from showing the film in Massachusetts, for the reasons set forth in the Attorney General's letter to Wiseman. An injunction was issued, and the producer appealed to the Supreme Judicial Court.

The highest state court affirmed, barring showing of the movies on two counts. In the first place, the court decided, Wiseman did not honor the contractual conditions imposed on him by the State in exchange for permission to make the film. The court found that only eleven or twelve releases were obtained and

that most of the inmates photographed were not competent to sign a release.

Secondly, noting that "the film shows many inmates in situations which would be degrading to a person of normal mentality and sensitivity," the court barred the movie as a breach of the inmates' privacy. The court ruled that the inmates have a right to privacy which the Commonwealth is duty-bound to protect. The inmates' right to privacy is, however, not absolute. They are protected by the court from exhibition of the film "merely to satisfy general public curiosity." But people with credentials which indicate that their curiosity is less general—legislators, judges, lawyers, sociologists, social workers, doctors, psychiatrists, students in these fields, and organizations dealing with problems of custodial care and mental infirmity—to whom exhibition "may be of benefit to the public interest, to the inmates themselves, and to the conduct of an important state institution," may view the film. "Because of the character of such audiences, the likelihood of humiliation . . . is greatly reduced," the court added.

Giving heed to the sensibilities of the Commonwealth of Massachusetts as well as to those of the inmates, the court concluded that "in view of the lapse of time since the film was made," any permissible showings of the film should include "a brief explanation that changes and improvements have taken place at the institution since 1966."

Norton v. Macy, U. S. Court of Appeals for the District of Columbia, July 1, 1969

Appellant, a former budget analyst at the National Aeronautics and Space Administration (NASA), was discharged for "immoral conduct" and for possessing personality traits which rendered him "unsuitable for further government employment." These findings of a civil service examiner, based solely upon appellant's alleged homosexual conduct one evening and his apparent admissions to a NASA official during an interrogation, were upheld by the Civil Service Board of Appeals. The U. S. District Court for the District of Columbia Circuit granted the Government's motion for summary judgment. On appeal, the U. S. Court of Appeals for the District of Columbia reversed, finding that appellant was unlawfully discharged and holding that the potential embarrassment to a Federal agency resulting from homosexual activities of an employee lacks a sufficient relationship to the efficiency of the employee's government service to justify his discharge without further inquiry.

The court noted that the Fifth Circuit Court of Appeals recently refused to consider a substantive attack on a dismissal for private homosexual conduct, apparently believing that it had no authority to review on the merits a civil service determination of unfitness [*Anonymous v. Macy,* 398 F. 2d 317, (1968)]. But the court in the instant case, while recognizing the wide discretion afforded by the Civil Service Commission in removing Federal employees—Civil Service Commission regulations provide that an appointee may be removed for "infamous . . ., immoral, or notoriously disgraceful conduct . . ."—said that due process sets at least minimal substantive limits on such discretion, forbidding dismissals which are arbitrary and caprici-

ous. In rejecting the Government's contention that once the label "immoral" is plausibly attached to an employee's off-duty conduct the court's inquiry into adequate cause is at an end, the court said that the Civil Service Commission does not have the expertise to make or enforce absolute moral judgments. The court added that a finding that an employee has done something immoral or indecent could support a dismissal without further inquiry only if all immoral or indecent acts of an employee have some ascertainable deleterious effect on the efficiency of the service, such as (1) when potential for blackmail jeopardizes the security of classified communications; (2) when sexual deviation is evidence of an unstable personality, unsuited for certain kinds of work; or (3) when contact with other coworkers or the public is impaired by notorious or open conduct. The court found that this case did not fit within any of the above categories, but rather that this dismissal was based on the custom within the agency to dismiss homosexual employees because continued conduct of this type might "turn out to be embarrassing to the agency;" and therefore the court declared that a hearing should have been conducted.

State v. Holt. Supreme Court of Tennessee, April 23, 1969; 37 L.W. 2646

At the trial of defendant for committing the crime of rape, his witness, a psychiatrist, was asked to give her opinion as to the mental condition of respondent at the time of the crime. The trial judge, apparently concerned that the psychiatrist, who made her examination in April or May of 1967, would offer her opinion of his sanity on November 1, 1966, the date of the alleged crime, on the basis of "subjective symptoms" observed during the post-offense interviews, refused to allow the witness to give her opinion. The defendant appealed, contending that this opinion evidence of the psychiatrist, an expert medical witness, on the sanity of the criminal defendant should have been admissible.

The Tennessee Supreme Court reversed, upholding the defendant's contention. The Court said that there is probably no class of cases where the use of expert testimony is so nearly indispensable as that involving sanity. It noted that when testimony is based on subjective symptoms—those which the doctor learns from a patient, as opposed to objective symptoms which are those a doctor finds from his own examination—it is open to supicion as having been influenced by the patient manufacturing or feigning symptoms. But the opinion stated, "it appears . . . that unless a psychiatrist be allowed to testify basing his opinions on subjective symptoms, then in most cases the jury will be denied expert opinion on a very complicated problem. . . . [T]he determination of mental status by its very nature requires the use of subjective findings. . . ."

Regarding the fact that the psychiatrist sought to offer an opinion formed in May on defendant's ability to know right from wrong the previous November, the Court said that this "goes to the weight to be given [the] testimony and not to its admissibility."

In re Marks. Supreme Court of California, April 30, 1969 (77 Cal. Rpt. 1)

Petitioner Marks, a former inpatient at the California Rehabilitation Center (CRC) now on outpatient status participating in a Synanon rehabilitation program, brought a writ

of habeas corpus to review the revocation of his outpatient status and his ordered return to the CRC as an inpatient by the State Narcotic Addiction Evaluation Authority (NAEA) upon petitioner's refusal to submit himself to periodic anti-narcotic testing. He contended that the Authority abused its discretion by suspending his outpatient status on the sole ground of his refusal to take the tests and that the suspension of his outpatient status was violative of due process. The Supreme Court of California found against petitioner on both counts, and discharged the writ.

In regard to the first point, the court noted that the state legislature provided for compulsory anti-narcotic testing as part of the "followup supervision" of all outpatients. This testing, particularly the "surprise" testing program, was designed not simply to detect past use of illegal drugs but also to deter their future use. In these circumstances, the court said, "we cannot say that the NAEA acted arbitrarily when it ordered the return to the CRC of an outpatient who flatly refused to participate in such an essential aspect of the program." The purpose of the CRC program is "not only to treat and 'cure' addicts, it is also to rehabilitate them," the court went on. "[A]lthough petitioner may give every appearance of being cured of his addiction, it is within the constitutional power of the legislature to require that a person once committed as a narcotic addict remain under supervision for a period sufficient to give reasonable assurance against relapse." And the court added that "an individual must (not) actually resume taking illegal drugs before his outpatient status can be suspended."

With respect to the petitioner's argument that the suspension of his outpatient status was violative of due process, the court said that the relevant statute did not provide for notice and hearing in connection with the suspension of outpatient status by the NAEA, and indicated that the absence of these express provisions was not constitutionally fatal.

The material in this section is based on summaries prepared by the Legislative Services Branch, Office of Program Planning and Evaluation, NIMH.

Mental Health News Digests

Katherine Hamilton Mental Health Center

A new community mental health center will be opening about a year from now in Terre Haute, Ind. where it will serve six counties—Clay, Greene, Parke, Sullivan, Vermillion, and Vigo—and a population of over 200,000.

The center is to be named for Miss Katherine Hamilton, a social worker who, until her death in 1961, was unusually active and effective in mental health work in Indiana.

Plans for the center began in 1964 when a Regional Planning Committee of 140 citizens from the six counties was organized. Financing will be shared, with the Federal government providing 50 percent, the State, 25 percent, and local funds (tax levies and private subscription) the remaining 25 percent. Total costs are estimated to be $2,250,000.

The center will be located next to the Union Hospital and will use some of its services, but the center will be a separate corporate entity. Four agencies are cooperating to form the center: the Adult and Child Guidance Clinic, Inc., the Vigo County Mental Health Association, the psychiatric unit of Union Hospital, and the Family Services Association.

The center's building, designed for maximum flexibility, will have about 45,000 square feet of space. The first floor will have outpatient services, offices, playrooms, group therapy rooms, and a dining area; the second floor will have a 40-bed inpatient unit (with most rooms for double or single occupancy), a six-bed children's section with a play area, and a wing that can, if necessary, be closed off as a secure area.

At the beginning the center will have inpatient service, outpatient service, 24-hour emergency service, partial hospitalization, and education and consultation (the five services considered essential for a comprehensive community mental health center), and it is hoped that a research program will be launched soon.

Dr. William C. Shriner, a psychiatrist, has been appointed medical director of the new center. (Digested from an article by Dr. A. W. Cavins in the October 1969 *Journal of the Indiana State Medical Association.*)

Mental Health Developments in Georgia

The State Board of Health has approved the Health Department's Mental Health and Mental Retardation construction plans, a necessary step to receive Federal funds. Under the new plans mental health and mental retardation are separated, rather than being lumped together as in previous arrangements. The new mental health plan calls for 32 comprehensive mental health centers throughout the State; nine centers are now in operation or in the planning stage.

Planning for a comprehensive community mental health center for Macon has been started, and a steering committee to prepare a staffing grant application has been named. Preliminary discussions on a proposed center for Peach, Pulaski, and Houston Counties are underway.

In addition to its service and teaching functions which began in 1965, the Georgia Mental Health Institute in its program for the 1970s will greatly expand its research program. Working in cooperation with Emory University, the nine research sections at the Institute are laying the ground-

work for a full-range research program, with biological, psychological, and sociological projects being planned.

A new treatment center for preschool emotionally disturbed children was opened in Atlanta. It will serve children of normal intelligence between the ages of three and six.

An aftercare clinic has been started in Muscogee County. The expanded service involving all members of the mental health team will allow many furloughed patients to remain in the community.

Volunteers from the Carroll County Mental Health Association are helping in the aftercare program. Every month when aftercare patients check in for their medication, the volunteers welcome them with coffee, doughnuts, and a pleasant social hour. This "nonbureaucratic" approach is effective in helping patients coming back on schedule.

The 19[illegible] Amendment to the Georgia Mental Health Code has two main sections. One is essentially a "bill of rights" for mentally ill patients. It emphasizes respect for the individual dignity of the patient and provides that (except for extreme emergencies) procedures used for criminals or those accused of crimes will not be used for patients. And "no person who is receiving or has received services for a mental disorder shall be deprived of any civil, political, personal, or property rights without due process of law." The other section is concerned with procedures for admitting patients to State institutions, and covers voluntary admissions, emergency admission, admission for evaluation, involuntary hospitalization, and judicial hospitalization. Certain parts of the new admission procedures may be accepted or rejected by the counties. (Based on material from *Georgia's Health, Crossroads,* and the *Journal of the Medical Association of Georgia.*)

Mental Health News from Texas

The Texas Board of Mental Health and Mental Retardation has approved State grants-in-aid of $4.5 million for community mental health and mental retardation centers and grants totaling some $320,000 from outside sources for State institutions. The State grants will provide major financing for the centers in 19 urban communities. To qualify for grants, community centers must provide 20–40 percent of State funds. Institutions receiving grants are the Abilene State School, Kerrville State Hospital, and Big Spring State Hospital.

Dedication ceremonies for the Mental Health/Mental Retardation Center for Greater West Texas were held in San Angelo on October 17, 1969. Participating were representatives of the Center's four sponsoring agencies—Angelo State University, City of San Angelo, San Angelo Independent School District, and Tom Green County.

Students from Notre Dame High School in Wichita Falls are doing volunteer work at Wichita Falls State Hospital. The students are enrolled in an elective course, "Lab Work in the Christian Apostolate." A five-day orientation session precedes their going into the wards, where they work on a one-to-one basis with the patients.

The first of a series of books containing the proceedings of annual conferences sponsored by the Texas Research Institute of Mental Sciences in Houston has been published by the

University of Texas Press. It is *Congenital Mental Retardation, Advances in Mental Sciences,* the topic of the 1967 conference. The 1968 conference was on drug abuse. Other conferences will be on the major psychoses, alcoholism, and gerontology. (From *Report,* issued by the Texas Department of Mental Health and Mental Retardation.)

Mental Health Mass Communications

The Department of Journalism at Kansas State University in Manhattan, Kansas, has a new program on mental health mass communications. It provides specialized instruction and accelerated training in communications skills relating to mental health and the behavioral sciences. Stipends are provided for eight students working in a program leading to the master's degree in journalism.

During their course of study, the students are acquainted with mental health and human services resources and encouraged to use these resources in covering the news.

One project in the program is publication by the students of an annual magazine, *Go Between.* The name of the magazine was chosen to indicate the journalist's unique role as "a communication link between an intelligent questioning public and personnel involved in the behavioral sciences."

Directors of the program are Dr. Deryl Leaming and Professor Everette Dennis.

Department of Human Behavior

The University of Southern California Medical School is establishing a Department of Human Behavior, rather than a traditional Department of Psychiatry. It will emphasize the behavioral sciences as sciences basic to the practice of psychiatry and will stress normal behavior. The department will be headed by Dr. Edward Stainbrook.

American Association of Psychiatric Clinics for Children

The Twenty-First Annual Meeting of the American Association of Psychiatric Clinics for Children was held in Boston on November 1–3, 1969. The meeting featured crucial issues confronting those who are delivering services to children and their families: treatment of the unwed teenage mother, psychotic children and their families, mental health services in the schools, recruitment of clinic personnel, and the interplay of psychiatrists, psychologists, and social workers were among the topics discussed.

The Association is made up of psychiatric clinics and services for children throughout the U.S. who meet the Association's standards. It was founded in 1948 as a result of efforts to set standards for children's psychiatric services by the Commonwealth Fund and the Division of Community Clinics of the National Committee for Mental Hygiene. Membership has grown from 54 clinics in 1948 to 157 in 1969. These public and private clinics employ some 8,500 child psychiatrists, clinical psychologists, psychiatric social workers, and other mental health professionals and paraprofessionals.

The Association provides leadership in defining and maintaining standards of clinical practice, organization of treatment, and specialized training. It has organized many regional and national conferences where new treatment approaches are presented.

One of its major activities is consultation. In places where no children's psychiatric services exist, the Association will help provide guidelines for determining need for such services, help in setting up a clinic—including architectural planning—and recommendations on planning. After being set up, the facility must meet the Association's standards before it can be accepted for membership. The Association, through its central office and committees, also consults with member clinics on all day-to-day aspects of clinic operation. For the general public, the Association acts as a referral service by supplying names of approved member clinics and also serves as a clearinghouse for information on child psychiatry.

World Mental Health Assembly

"Mental Health in the Community" was the theme of the 1969 World Mental Health Assembly held in Washington, D.C. November 17–21, 1969.

An international group of mental health professionals and mental health association volunteers and staff participated in the Assembly, which was comprised of the annual meetings and assemblies of the World Federation for Mental Health and the National Association for Mental Health.

This marked the first time that the World Federation for Mental Health has held an annual meeting in the United States. The Federation includes in its membership more than 169 associations and 2,300 individuals in 52 nations. It works with member associations to improve the mental health services in their own countries, and promotes exchange of knowledge through its annual meetings. The Federation also serves as consultant to the Economic and Social Council of the United Nations, UNESCO, World Health Organization and UNICEF. G. Morris Carstair, M.D., professor of psychological medicine at the University of Edinburgh, is president.

The National Association for Mental Health, founded in 1901 by former mental patient Clifford Beers, is dedicated to "reform and education in the field of mental and nervous disease." First known as the National Committee for Mental Hygiene, it merged with the National Mental Health Foundation and the Psychiatric Foundation in 1950. It now has over 1,000 State divisions and local chapters. Nationwide publicity campaigns and efforts by local chapters are aimed at educating the public and those groups that come into contact with the mentally ill. Clergymen, public health nurses, policemen, social workers, recreation workers, nursing home directors, and attorneys work with the mental health associations to increase community understanding.

Each year the Association makes several awards to those who have contributed to its goals. This year Senator Ralph W. Yarborough (D.-Tex.) and Representative Harley O. Staggers (D.-W.Va.) were honored for their initiative and leadership in introducing legislation that would renew and extend the Community Mental Health Center Act. Barbara Field Benziger, author of *The Prisoner of My Mind,* and Clara Claiborne Park, author of *The Seige,* received awards for their contributions to mental health. Recipients of the Mental Health Bell Award given to the daily and non-daily newspapers with the best year-round coverage were the *Osawatamie Graphic News,*

Osowatamie, Kans., and the *Dayton Daily News,* Dayton, Ohio. Employer of the Year Award for employment of the mentally restored went to Carson, Pirie Scott and Co., Chicago, Ill. The Katherine Hamilton Volunteer of the Year Award given annually by the Indiana Mental Health Association went to Mrs. Maxine Bright of Blackfoot, Idaho.

The new president of the Association is James Chapman of Cleveland who succeeded Mrs. Burton Joseph of Minneapolis.

Training in Mental Health Statistics

A master's degree program in mental health statistics is offered by the Biostatistics Department of the University of North Carolina School of Public Health. The program consists of two semesters of courses in statistics, epidemiology, public health, and application of mental health statistics to mental health, followed by a 10–12 week field experience in an agency using mental health statistics. Information about the program is available from Dr. Donna R. Brogan, Biostatistics Department, UNC School of Public Health, Chapel Hill, N. C. 27514.

Report of the Joint Commission on Mental Health of Children

The final report of the Joint Commission on Mental Health of Children will be entitled *Crisis in Child Mental Health: Challenge for the 1970s.* It will be available from Harper and Row in the Spring of 1970. Several other publications on special topics in child mental health are also to be published.

A digest of the final report has also been prepared. It is available from the Joint Commission on Mental Health of Children, 1700 Eighteenth St., Washington, D.C. 20009, for $1.50. Checks or money orders made payable to the Joint Commission must accompany the order.

Training for Mentally Ill Children

"A Home Training Program for Young Mentally Ill Children" by Nanette Doernberg, Bernard Rosen, and Tomannie T. Walker was recently issued by the League School for Seriously Disturbed Children. It describes the research program of the School, in which the effectiveness of a training program for parents was evaluated.

The League School is a day treatment and rehabilitation center in Brooklyn, N. Y. It was one of the first day schools for disturbed children whose families wanted to keep them at home, rather than place them in a residential center or hospital. Founded in 1953, the School now has an enrollment of 80 children of elementary school age who attend five days a week.

Education is the primary treatment approach. In most classes there are three students and one teacher.

As in many similar facilities, the School has a waiting list of children who have applied for entrance. The research was designed to examine the effectiveness of a home training program in which the "waiting list" child had only a one-hour per week training session at the school with the mother present. The mother also received advice and instruction individually and in a weekly group session. Results indicate that a program of this kind can be effective.

Director of the School is Dr. Carl Fenichel and the address is 567 Kingston Ave., Brooklyn, N. Y. 11203.

Juvenile Delinquency Reporter

The *Juvenile Delinquency Reporter,* a new newsletter, is intended to provide timely pertinent information about the Juvenile Delinquency Prevention and Control Act of 1968 as well as the broader aspects of delinquency prevention, treatment, control, and rehabilitation. The first issue contains information about the 116 grants awarded in fiscal year 1969. Requests to be placed on the mailing list should be sent to the Department of Health, Education, and Welfare, Office of Juvenile Delinquency and Youth Development, Room 1427 South, Washington, D.C. 20201.

Discoveries in Biological Psychiatry

A three-day symposium on "Discoveries in Biological Psychiatry" will be held on April 17–19, 1970 at the Taylor Manor Hospital. It will feature presentations by the "discoverers" of psychotropic drugs and biological therapies. Speakers include Drs. Albert Hofman (Switzerland), Hugo Bein (Switzerland), Pierre Deniker (France), Paul Janssens (Belgium), J. Ravn (Denmark), Ronald Kuhn (Switzerland), John J. F. Cade (Australia), Nathan S. Kline (U.S.), Barry Blackwell (U.S.), Tracy Putnam (U.S.) Chauncey D. Leake (U.S.), Lothar B. Kalinowsky (U.S.), John C. Krantz, Jr. (U.S.), Frank M. Berger (U.S.), Irvin M. Cohen (U.S.), and Frank J. Ayd, Jr. (U.S.). Drs. Gerald Dorman, president of the American Medical Association, and Raymond W. Waggoner, president of the American Psychiatric Association, will also speak. The address of the Symposium Secretary is Taylor Manor Hospital, Ellicott City, Md. 21043.

recent nimh publications

Single copies of these publications may be obtained from the Office of Communications, National Institute of Mental Health, LL02, 5454 Wisconsin Ave., Chevy Chase, Maryland 20015. A complete list of all publications available from the NIMH may also be obtained from the Office of Communications. If a price is given, the publication may be ordered in quantity from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Enclose a check or money order payable to the Superintendent of Documents.

Consultation in Mental Health and Related Fields. A Reference Guide. This 112-page bibliography is a "reasonably comprehensive" compilation of items dealing with the practice of consultation. It covers consultation by fields of practice, use of consultation in various settings, forms of consultation, professional roles in consultation, process of consultation, planning consultation programs, consultation training and education, and research, evaluation, surveys, and reviews. There is also a list of films related to consultation practice. Compiled by Fortune V. Mannino, Ph.D. of the Mental Health Study Center, NIMH. Public Health Service Publication No. 1920. 50¢.

Recent Research on Narcotics, LSD, Marihuana and Other Dangerous Drugs. This 20-page report is based on testimony presented before Congress by Stanley F. Yolles, M.D., Director, NIMH. Public Health Service Publication No. 1961. 20¢.

Resource Book for Drug Abuse Education. The NIMH Drug Abuse Education Project of which this publication is a part was performed under contract with the American Association of Health, Physical Education, and Recreation and the National Science Teachers Association of the National Education Association. The Resource Book contains summaries of factual information on the major drugs of abuse, and techniques and suggestions that experienced drug educators have found helpful. A section on planning drug abuse education workshops is included. Public Health Service Publication No. 1964. $1.25.

Social Aspects of Alienation. An Annotated Bibliography. This is a 100-page bibliography with detailed annotations with emphasis on empirical work during 1959–1968. Prepared by Mary H. Lystad, Ph.D. National Clearinghouse for Mental Health Information, NIMH. Public Health Service Publication No. 1978. $1.00.

Psychologists in Mental Health: 1966. This is a detailed analysis and report based on the 1966 National Register of Psychologists of the National Science Foundation. Prepared by Donald R. Jones, Ph.D. of the Manpower and Analytic Studies Branch, Division of Manpower and Training Programs, NIMH. Public Health Service Publication No. 1984. 45¢.

Private Funds for Mental Health. This is an annotated list of foundations and other private granting agencies that support research, training, or services in mental health and related disciplines. Prepared by John E. Hinkle, Colorado State University, under contract with the Behavioral Sciences Research Branch, Division of Extramural Research Programs, NIMH. Public Health Service Publication No. 1985. 25¢.

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